HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE
PREPARED BY THE DEPARTMENT OF HEALTH
AND SOCIAL SECURITY

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Health Services Manpower Review, Department of Adult Education, University of Keele, Keele, Staffs. ST5 5BG, England.
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Ospedale, Corso Turati 46, 10128 Torino, Italy. l.1,000
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Technische Gids voor Ziekenhuis en Instelling, Tesselschadestraat 18-22, Amsterdam, Netherlands.
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HOSPITAL ABSTRACTS

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HOSPITALS IN GENERAL

See also Abstract No. 1583

1579. TUCKETT, D. and KAUFERT, J. M. editors. **Basic readings in medical sociology.** London, Tavistock Publications, 1978, xxiv, 306pp. £4.95

This volume is intended as a companion to 'An Introduction to Medical Sociology' by D. Tuckett, 1976, (See Hospital Abstracts Vol. 16, Abstract No. 767) and is an attempt to bring together in an economical and manageable way many of the source materials discussed in it. The readings cover such aspects as: sociology as a science; medical education and sociology; the family, marriage, and its relationship to illness; work, life chances and life styles; becoming a patient; doctors and patients; the organization of hospitals; social causes of diseases; the social definition of illness; and doctors and society. A list of references (pp. 283-292), a name index and subject index are included.

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 1627, 1651

1580. Zur Situation der Hamburger Krankenhäuser. **[On the situation of Hamburg hospitals.]** *Krankenhaus-Umschau*, Kulmbach, 1978, May, vol. 47, no. 5, pp. 299-304.

On the occasion of the 61st annual congress of the Association of Administrators of German Hospitals, held in Hamburg in June 1978, this paper presents a survey of present day hospital services in the city. There are 14 public hospitals (two of which, the University Hospital, Eppendorf, and the General Hospital, Altona, are particularly large and comprehensive), with 10,000 beds; 18 hospitals run by charitable organizations, with 4,300 beds; 4,800 psychiatric beds; and some 1,400 beds in private and other hospitals. Hamburg is also an important medical centre which, among other things, pioneered joint prostheses in Germany and has five centres for implanting pacemakers. The paper includes six photographs of Hamburg hospital complexes.

1581. LAAGE, G. Kreiskrankenhaus Gunzenhausen; Landkreis Weissenburg-Gunzenhausen. **[Gunzenhausen district hospital: Weissenburg-Gunzenhausen rural district.]** *Krankenhaus*, Stuttgart, 1978, May, vol. 70, no. 5, pp. 187-191.

The new 220-bed Gunzenhausen District Hospital was completed in 1976 and has a T-shaped design. The carpeted entrance area on the ground floor is intended as a meeting place for ambulant patients, visitors and staff and has a self-service shop, a café, a hairdressing salon and a savings bank. Everything possible has been done to eliminate a hospital atmosphere. The three upper floors each have two 18-bedded wards on a double corridor plan (five three-bedded rooms, one two-bedded and one

single room) on each of two wings while the third wing houses treatment areas. Meals on trays are distributed via a paternoster lift system. The paper is illustrated with three photographs, a site plan, two floor plans and a sketch plan of a patient's room.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract Nos. 1591, 1596, 1701

1582. RATCLIFFE, S. **The DHSS health building system as a whole.** *Hospital Engineering*, London, 1978, May, vol. 32, no. 4, pp. 4-8.

Much of the work in procuring and operating a building is routine. If a systematic technique could be employed, aided by computer methods where these were useful, much could be gained. The data being handled is basically the same, although modified in its direction of output. The health building system described assembles and identifies the processes involved to provide a logical route map, provide an easily accessible data store, and make available various computer aids for the procurement of health buildings. Three main streams of work are developed: rationalization of data; rationalization of methods; and rationalization of techniques using the computer when economical. The system is seen as having three levels: (i) reference library or data base; (ii) the level where the major activities take place (some computer-assisted, some manual), for example, whole hospital policies and design, preparation of bills of quantities, project construction; and (iii) the operations needed to complete the project. Brief details are given of the progress made to date.

1583. CARRILLO, R. Leyes filogeneticas del hospital. **[The laws that favour hospital growth.]** *Policlinica*, Barcelona, 1978, May, no. 46, pp. 10-14, 17-18, 21.

The author discusses and illustrates by means of 10 diagrams the architectural aspects of the following five 'laws': (i) every hospital should be designed and constructed in such a way that, like a tree, it can grow in harmony with the growth of the surrounding population; (ii) hospital prototypes must grow out of each other, from the smallest, simplest forms to the largest, through a process of logical and organic development and growth; (iii) when the in-patient sector expands, all the other sectors must expand in harmony, in particular the general services; (iv) structural growth is quantitative and correlative between the different sectors of the hospital, but functional growth is qualitative and proceeds from undifferentiated homogeneity to differentiated heterogeneity: (v) the different services within the hospital are separated from one another by stages, but the functional integrity of each sector must be maintained.

HOSPITAL DESIGN

See also Abstract Nos. 1582, 1588

1584. RAWLINSON, C. **Space utilization in hospitals: concepts, methodology and preliminary results.** (M.A.R.U. 5/77) London, Medical Architecture Research Unit, Polytechnic of North London, 1977, [x], 168pp. £1.50

This report is divided into four main sections and aims to examine the problems of

the use of space in hospitals. The problems have been tackled in two ways, either through empirical case studies of space utilization in selected hospitals or by theoretical work on space classification. The first section of the report provides a background discussion of the concepts of space utilization and multi-use of space as they apply to hospitals. The second section outlines the methodology developed both for carrying out the case studies and for the theoretical work on space classification. The third section examines the results of the study; and the fourth section summarizes the results for the first case study hospital and demonstrates their potential impact on space utlization in existing hospitals and on the current guidance available for estimating space requirements. The method of approach adopted in the study is also evaluated.

1585. RAWLINSON, C. and KELLY, J. **Space utilization in hospitals: Lister Hospital study.** (M.A.R.U. 3/78) London, Medical Architecture Research Unit, Polytechnic of North London, 1977, vii, 139pp. £2.00

The purpose of this paper is to present the results of a case study carried out by the Medical Architecture Research Unit under the sponsorship of the Department of Health and Social Security. The framework of concepts, methodology and techniques within which this study was carried out are described in a separate report (see Abstract No. 1584). This study analyzes the survey area; the teaching spaces, libraries and seminar and conference rooms; operating theatres; ward and consultant's offices; treatment rooms; dining, snack facilities and rest rooms; central changing areas; waiting areas; and day rooms. Two lists of 50 figures and 30 references are included.

1586. KRUISHEER, J. E. Die Integration des Krankenhauses in seine städtische Umgebung. **[Integrating the hospital with the urban environment.]** *Krankenhaus Umschau*, Kulmbach, 1978, April, vol. 47, no. 4, pp. 218, 221-224, 227.

The author, a Dutch architect, discusses the main factors which affect the integration of a hospital into the community which it serves. These fall under three heads: (i) the site of the hospital: this should be in the centre of the community and not on its periphery; (ii) the hospital should be easily accessible to all; and (iii) the hospital building should fit in with the other buildings in the centre of the community. The paper includes illustrative diagrams and photographs of hospitals.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract No. 1581

1587. **New addition planned for future individual departmental growth.** *Hospitals*, Chicago, 1978, May 16, vol. 52, no. 10, pp. 59-60, 62.

The recently completed major addition at Humber Memorial Hospital, Western, Ontario, was planned and designed to allow expansion both overall and of individual departments. The basement and first two floors form a podium. The basement houses laboratory, central supply, pharmacy, catering and other support services. On the ground floor, a diagonal central circulation spine runs from the main entrance to the out-patient department at the rear. The circulation spine provides access to all patient care departments on this floor so that they can be expanded individually; on the first

floor the surgical suite and maternity department can be expanded similarly. Mechanical supply and exhaust systems are grouped vertically at the rear of the building. This large mechanical space can be expanded vertically to serve future floors. Plans of the ground and first floors and two photographs are included.

1588. GAISER, H. Die Entwicklung der Planung des Neubaues des Evangelischen Krankenhauses Kusel 1973-1977. **[The development of the planning of the new building of the Evangelical Hospital, Kusel, 1973-1977.]** *Krankenhaus Umschau*, Kulmbach, 1978, March, vol. 47, no. 3, pp. 163-168.

The planning of the new Evangelical Hospital at Kusel (Rhineland-Palatinate) extended over the years 1973 to 1977, and during this period changes were made in the design which took into account modern concepts of hospital design. Originally 330 beds were planned but the 1975-76 project reduced this to 318: this design consisted of a podium with treatment and service areas, above which rose the ward block. The final 1977 plan however took more advantage of the sloping site and provides for two parallel linked buildings, one for treatment and service areas and one for the ward block. This meant that the treatment block was not so deep and more use could be made of daylight. The 1977 plan reduced the bed occupancy to 270. The final 1977 plan fits better into the landscape and lines of communication are simpler. The paper includes photographs of models of the 1975-76 and the 1977 designs and plans of the ground and first floors of both designs.

DESIGN OF SPECIAL DEPARTMENTS

1589. TORNAR, R. M. Neues Schul- und Internatsgebäude der Schwesternschule St. Pölten. **[New school and residential building of the nurses school at St. Pölten.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Feb., vol. 19, no. 2, pp. 109-110, 113.

The new building for the school of nursing at St. Pölten, Lower Austria, was officially opened in September 1977. The ground floor houses the assembly hall, lecture rooms, model ward, and other facilities. In the basement are the gymnasium, library, laboratory, sewing rooms etc. The seven upper floors each have 12 bed-sitting-rooms for students, each of which takes a maximum of three beds, together with wash rooms, small kitchen etc. The number of students attending the four-year course in September 1977 was 270, of whom 17 were males. The school can be used for refresher courses for medical staff and for symposia. The old building is in process of being adapted for offices, service rooms, dining rooms, and some residential accommodation.

WARDS AND PATIENTS' ROOMS

1590. NOBLE, A. and DIXON, R. **Ward evaluation: St. Thomas' Hospital: report for the District Management Team of St. Thomas' Hospital.** (M.A.R.U. 7/77) London, Medical Architecture Research Unit, Polytechnic of North London, 1977, [ix], 154pp. £2.50

This study was designed to evaluate the way in which the three ward designs used

within St. Thomas' Hospital, London, functioned as acute medical and surgical wards in the context of the policies, requirements and expectations existing in the hospital at the time of the study. The study is divided into eight sections which cover: description of the hospital and the wards; establishing a basis for comparison; discussion and development of the model requirements; and case studies of the South Wing, East Wing and North Wing wards. Seven appendices are included which consider: comparative statistics for the various ward types; surveys of the use of single rooms; use of sanitary facilities, day rooms and treatment rooms; safety in fire; survey of sisters and patients; questionnaire survey of doctors; and analysis of the patient survey.

NURSES' HOMES

See Abstract No. 1589

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

1591. OLIVER, B. C. **The DHSS health building system: its engineering components with particular reference to the design and commissioning sub-systems.** *Hospital Engineering*, London, 1978, May, vol. 32, no. 4, pp. 10-18.

After outlining the more important aspects of the background to the concept of the health building system and how the design aids that are envisaged will fit into it, this paper describes one of the most complex and technically interesting of these aids—the services co-ordination and modelling program (SCAMP). SCAMP is a general-purpose or utility application, which will enable the user to build a fully co-ordinated physical model of the engineering services, as he wants and at any stage in the design, using as basic input the building design and the structural design from the project file and the engineering components from the neutral file. The essential features of the package and its application are described. The engineering component catalogue which is an essential part of the neutral engineering data file is briefly mentioned. Progress to date is outlined.

COMMUNICATION SYSTEMS

1592. GENSHEIMER, K. Die Patienten-Ruf- und Sprechanlage im Zweckverbandskrankenhaus Schwelm aus planerischer Sicht. **[The patients' calling and speaking equipment in the Schwelm local administration union hospital from the planning point of view.]** *Krankenhaus-Umschau*, Kulmbach, 1978, May, vol. 47, no. 5, pp. 344, 347-349.

For the first time in Germany a 433-bed hospital at Schwelm has recently had a co-axial cable communications system installed. This paper gives an account of the

nurse-call system which was finally chosen after a thorough study of the possible alternatives. The system selected routes all calls via a central point from where they are relayed to the appropriate nurse. The system, which is described in detail, is the first of its type to be commissioned and has proved itself in practice.

1593. GECSER, O. Csöposta. **[Pneumatic tubes in Hungarian hospitals.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1978, March, vol. 16, no. 1, pp. 44-52.

Owing to the shortage of labour it has become necessary to equip hospitals with pneumatic tube systems in Hungary. In addition to the technical data of the pneumatic tube systems, the author outlines the expected economic and other possible advantages. It is recommended that older hospitals should also have the pneumatic tube system installed.

HEATING

1594. UNITED STATES. HEALTH RESOURCES ADMINISTRATION. ENERGY ACTION STAFF. **Total energy management for hospitals,** (DHEW Publication No. (HRA) 77-613) Washington, U.S. Government Printing Office, 1977, v. 78pp.

The aim of this publication is to identify proven techniques for conserving energy and energy dollars in hospitals. These techniques together comprise Total Energy Management (TEM). TEM provides the flexibility to conserve energy and to cut costs while meeting health care and related requirements. Aspects considered include: initiating a TEM scheme; developing energy consumption data; conducting the facility survey; guidelines for energy conservation; developing and implementing the basic plan; financial considerations; communication and motivation; and methods of monitoring the scheme. Two appendices are included presenting sources of information on energy management; and building information for total energy management. A glossary, list of abbreviations and a bibliography of 43 items are also included.

1595. BÖNI, W. Die kohlenbefeuerte Heizzentrale. **[The coal-fired heating system.]** *Veska*, Aarau, 1978, April, vol. 42, no. 4, pp. 192-193.

The expected decline in the supply of other forms of fuel makes coal, supplies of which should last for hundreds of years, an attractive proposition for heating installations. This paper describes the new coal-fired system installed at the Westphalia State Hospital at Eickelborn, West Germany. Here a steam production of 18 tonnes/hour are needed to provide the total requirement of 15,400,000 Kcal/L. The three coal-fired boilers produce steam at 20 atmospheres and a temperature of 325°-350°C. Pressure reduced to 0.5 atmospheres provides, with the aid of a counter flow turbine, electrical energy which gives 60 per cent of total requirements. One of the boilers has merely a stand-by function. The automatic supply of coal and removal of waste are entirely dustproof and the installation remains absolutely clean. Only two workers per shift are needed to man the boilers. It is suggested that in Switzerland, where conditions are somewhat different, boilers should be fired on a dual basis (coal/oil or gas/oil).

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 1598

1596. TUTHILL, R. J. **The DHSS health building system: the maintenance and operations sub-systems.** *Hospital Engineering*, London, 1978, May, vol. 32, no. 4, pp. 19-22.

This paper first considers the objectives of those involved in maintenance and operations, and indicates the size of these functions together with some of their historical background. It identifies some of the fields of work with which the Department of Health and Social Security Engineering Division is concerned in connection with maintenance and operations, including reference to developments in the application of computer aids to maintenance management. The paper goes on to review the various relevant types of official guidance material, making particular mention of Estmancode (the estate management practices code for the National Health Service) and various points of current interest.

SANITARY EQUIPMENT AND FITTINGS

1597. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and WELSH OFFICE. **Cold water supply storage and mains distribution.** (Health Technical Memorandum No. 27) London, HMSO, 1978, 74pp. £5.00

This Technical Memorandum is intended as a guide for engineers, architects, service engineers, surveyors, contractors and for others interested in the design and installation of cold water supply pipework and distribution systems in hospital and health building complexes, from the source of supply to the local cisterns (excluding waste water preventers for WCs), but not including the outgoing services except where necessary for clarification. Aspects considered include: source of supply; water treatment; water storage; distribution pipework; pumps and pumping systems; sterilization of the completed installation; commissioning and maintenance; and water tariff. Eight appendices are included covering: water consumption; water plant; storage and pumping system layouts; Department of Health and Social Security standard specifications on water supply; specification for capillary jointing; Regional Health Authorities and Regional Water Authorities boundaries; a select list of references to British Standards, British Standard Codes of Practice, Her Majesty's Stationery Office Publications, Institution of Electrical Engineers regulations; and the Chartered Institution of Building Services guidebook; and names and addresses of bodies and authorities referred to in the text.

EQUIPMENT, FITTINGS, FURNITURE

FLOORS AND FLOOR COVERINGS

See Abstract No. 1662

BEDS, COTS, ETC.

See Abstract No. 1682

EQUIPMENT GENERALLY

1598. SELMAN, A. C. **The DHSS health building system: specialist services.** *Hospital Engineering*, London, 1978, May, vol. 32, no. 4, pp. 25-30.

Electronic and biomedical engineering equipment and its maintenance has not, to date, received the degree of attention that it merits, since it is associated directly with patient care. This paper discusses the cost implications, the activities to be undertaken, staff training, and documentation.

1599. HENRY, J. B. and ROENFELDT, R. L. **Cost analysis of leasing hospital equipment.** *Inquiry*, Chicago, 1978, March, vol. 15, no. 1, pp. 33-37.

This paper provides information concerning interest rates on true leases and lease-purchase agreements for hospital equipment. Since the salvage value estimate is extremely important for determining the effective rate of a true lease contract, various estimates are used. This procedure provides the analyst with a range of rates comparable with the debt rate and also indicates the sensitivity of the lease rate to changes in salvage values. The effective rates on the lease and lease-purchase contracts obtained from South Carolina hospitals were quite high. Most rates ranged from 12 to 25 per cent, depending upon the salvage value estimate. But some rates were considerably higher, with one having a rate of 87 per cent.

ELECTRONIC EQUIPMENT

See also Abstract Nos. 1598, 1691, 1713

1600. SPEARS, A. **Ultra-sonic diagnostic equipment, research and development.** *Health Bulletin*, Edinburgh, 1978, May, vol. 36, no. 3, pp. 136-137.

A seminar was held by a Sub-Group of the Equipment Research Committee of the Scottish Home and Health Department in September 1976 to discuss the present state of research and development in ultra-sonic equipment. The Sub-Group subsequently issued a report which included the following recommendations: (i) that new devices to improve display should be evaluated; (ii) that the diagnostic quality of scanning should be monitored; (iii) that the value to diagnosis of CAT scanning and ultra-sonic imaging should be compared; (iv) that research in the use of scanning in new clinical areas should be encouraged; and (v) that more doctors should be trained in the techniques of ultra-sonic diagnosis.

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract No. 1721

RECRUITMENT AND MANPOWER

See also Abstract Nos. 1610, 1616, 1624

1601. PARKHOUSE, J. **Medical manpower in Britain. III. Actual manpower developments in relation to predictions and recommendations.** *Medical Education*, Oxford, 1978, March, vol. 12, no. 2, pp. 133-142.

This paper discusses various estimates of and recommendations on medical staff requirements in Britain and relates them to actual developments. The aspects covered include: numbers of medical graduates; total numbers of doctors; hospital medical staff; general practitioners; university and research staff; community medicine; occupational health; overseas doctors; women doctors; retirement; emigration and immigration; distribution between grades; distribution between specialties; and geographical distribution.

1602. PARKHOUSE, J. **Medical manpower in Britain. IV. The present position.** *Medical Education*, Oxford, 1978, March, vol. 12, no. 2, pp. 143-158.

This paper first describes the sources of British data on medical manpower. Although the amounts of information available about doctors are far in excess of what can be found elsewhere in the world, there remain problems of delay, inadequacy, incompleteness, and lack of organization. The manpower decision-making process is outlined. The criteria used include: local assessment of 'need' at hospital or district level; a regional concept of staffing norms or levels; and national targets. Criticisms of the present process are: that it is cumbersome and insufficiently clear in its objectives; and that the criteria are based on adding to the existing data. In any rigorous analysis of the medical manpower situation there must be three stages for examining the question of 'need' or 'demand': knowing the number of people actually available; knowing what the current establishment of posts is; and determining what the established number of posts should be in order to provide a determined range of services. Some long-standing difficulties which can be directly related to a lack of clear policy of national level are discussed.

SALARIES AND SUPERANNUATION

See Abstract No. 1606

STAFF MANAGEMENT

See also Abstract Nos. 1611, 1612, 1628, 1726

1603. SOÓS, L. Munkaszervezés az integrált egészségügyi intéményekben, 1. **[Labour organization in hospital-polyclinic units. 1.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1978, March, vol. 16, no. 1, pp. 11-28.

The author discusses the tasks of the system-oriented labour organization in the field of the integrated preventive-curative health services. The possibilities of having a logically based description of the organization are also considered. The simple block scheme of the administration as well as the diagram of the institutes controlled

by the Local Councils are presented. The in- and out-patient department is presented as a combination of regulation circles. The regulations and directives of the Ministry of Health enable an up-to-date management and an effective labour force to be established from both practical and theoretical points of view.

STAFF RELATIONS

See Abstract No. 1619

STAFF TRAINING

See also Abstract Nos. 1589, 1609, 1613-1616, 1623-1624, 1629, 1689

1604. KING, P. J. **The hospitalwide education department.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, April, vol. 8, no. 4, pp. 13-19.

The trend towards centralized non-medical education and training activities in the hospital has caused nursing administration to fear loss of control over nursing education. However, hospital administrators in the United States are finding that education departments concerned with the whole hospital are helping them to: (i) meet accreditation requirements; (ii) improve communication between departments; and (iii) contain costs. Nursing staff development can be effectively organized by the use of a centralized education department linked to nursing education by a clinical director from the nursing department. In this way, many kinds of educational expertise can be drawn upon, but the bulk of clinical teaching can be handled by clinical specialists attached to nursing units.

STAFF WELFARE

See also Abstract Nos. 1607, 1617, 1618, 1668

1605. HEALTH AND SAFETY EXECUTIVE. **Pilot study: working conditions in the medical service.** London, Health and Safety Executive, 115pp. £2.00

This report on hospital services in the North West Thames region of the National Health Service is an assessment of conditions found in the establishments visited within boundaries of one regional health authority, and is in no sense a scientifically based sample survey. The report is in five sections, and section one considers the structure and nature of the activity; responsibility of employers to employees; duties of those in control of premises; responsibility of employees and other persons; and consultation with staff representatives. Section two considers hazards common to other activities subject to accepted levels of safety; hazards peculiar to the activity; and accident reports and experience. Section three examines occupational health services and training; section four considers current sources of guidance; and section five comments on existing guidance and standards of compliance. There are six appendices which list the professional organizations consulted; the programme at one particular hospital; numerical breakdown of premises; numerical breakdown of employees; ambulance service standing orders; and the radiological component.

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract Nos. 1601, 1602, 1619, 1657, 1689

1606. REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION. **Eighth report, 1978** (Chairman: Sir Ernest Woodroofe) (Cmnd. 7176) London, HMSO, 1978, v, 95pp. £1.60

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971 to advise the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service. This report presents the evidence submitted to the Review Body and the consequent recommendations. Four appendices are included: detailed recommendations on remuneration; movements in doctors' and dentists' earnings to April 1977; change in real incomes after tax April 1975-April 1977; and survey of consultants' pattern of work and responsibilities in the National Health Service.

1607. ELLIOTT, F. R. **The conflict between work and family in hospital medicine.** *Health Bulletin*, Edinburgh, 1978, May, vol. 36, no. 3, pp. 128-130.

The implications for family life of hospital doctors' work commitments were studied by the author in Edinburgh. Heavy workloads meant that: (i) 42 per cent of wives found problems in managing the household single-handed; (ii) 26 per cent of doctors and 55 per cent of their wives said their social activities were restricted; (iii) 45 per cent of couples found the limitation of father-child interaction a problem; and (iv) 16 per cent of doctors and 71 per cent of wives felt deprived of their spouse's companionship. Some doctors are trying to solve the conflict between work and family commitment by attempting to reduce their workload, either by changing their career patterns or through militant action.

NURSING STAFF

See also Abstract Nos. 1589, 1604, 1677-1679

1608. MAGGS, C. J. **Towards a social history of nursing I.** *Nursing Times*, London, 1978, May 18, vol. 74, no. 20, occasional papers pp. 53-56.

Nursing may rightly be regarded as part of the social history of modern Britain and as an aspect of women's work. This raises new questions about nursing and women's roles past and present. In examining new perspectives, 'traditional' sources are re-assessed, but more importantly new sources are briefly considered. Attempting to define 'rank and file' experiences involves different historical techniques and there is an urgent need for more in-depth historical research.

1609. SCHLOTFELDT, R. M. **The professional doctorate: rationale and characteristics.** *Nursing Outlook*, New York, 1978, May, vol. 26, no. 5, pp. 302-311.

The thesis of this paper is that the time is right for the development of programmes

of pre-service nursing education which merit the award of a professional doctorate. The rationale for such a degree derives from the nature of nursing, the contribution that nurses can make to the development of an exemplary health care system, the recognized need for nursing to emerge as a fully-fledged profession, pride in past accomplishments of nurses, discontent with the meagre accomplishments of nurses at present, anticipation of the future it will create, and the confidence that nurses can and will so influence the health care system that all persons will be properly served for care. Proposals are made on the characteristics required of courses leading to a professional doctorate, with particular references to the students, the faculty, the place of study, and the curriculum and its organization.

1610. GINGRAS, P. **Analysis and planning for improved distribution of nursing personnel and services: national conferences** (DHEW Publication No. (HRA)77-3) Bethesda, Md., Public Health Service, Division of Nursing, 1976, vii, 91pp.

As a result of the new mandate on planning in the United States, and the increasing concern for improving the distribution of nursing services and resources, a project on the 'analysis and planning for improved distribution of nursing resources and services' was established. Two national conferences were held in 1975 and 1976 as part of the project. This publication, in addition to containing the proceedings of the second conference, also includes several pertinent papers presented at the first conference. Papers presented include: planning for nursing; measuring nursing supply; nursing legislation; analytical approaches to planning; nursing initiatives; nurses and health systems agencies; data issues in nursing; proposed policies; minority issues in nurse manpower planning; and a summary of the workshop. A list of participants at the second conference and a short annotated bibliography of 16 items are included.

1611. LAROSE, O. and MOUCHEL, N. D. Le contrôle professionnel: fonction exclusive et/ou partagée d'un cadre en nursing. **[Professional control: exclusive or shared role in nursing.]** *Administration hospitalière et sociale*. Montreal, 1978, March/April, vol. 25, no. 2, pp. 12-19.

The authors ask whether control of nursing standards should be the responsibility of qualified nurses only, and, in particular of the director of nursing and/or the professional nursing bodies, or whether this task should be shared with the health administrators. They suggest that the nursing profession itself should ensure that the overall control of the quality of nursing care becomes a reality at all levels and for this purpose the profession should develop various evaluation programmes for every sphere of nursing. To be effective, these programmes must be integrated into the health system and take account of all the factors involved in the organization of the nursing services. The administrators also have a role to play in the monitoring of standards; they have a control function within an administrative process related to the management of the institution. The nursing profession has a control function within the professional process and makes a judgement on the quality of nursing so as to protect the public and guarantee the competence of the members of the profession. The authors briefly outline a programme for evaluation in nursing, which takes account of structure, content, result, process, and impact.

1612. BROUSSEAU, R. L'implantation d'un processus de contrôle: une approche conceptuelle pour le directeur des soins infirmiers. **[The establishment of a control system. A conceptual approach for the director of nursing care.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 38-41.

The responsibility of the director of nursing is to ensure that his or her system produces the desired results. This implies that the desired results are identified and that sufficient resources are allotted to achieving these results. Performance must therefore be monitored by some yardstick, and deviations from the optimum must be identified, analyzed, and dealt with. This in turn requires that the objectives of the monitoring process strategy be determined, and that the information required be defined, and methods for collecting this information identified. The next stage is the processing of the information; decisions must then be taken as to what adjustments are required and these adjustments made. The degree of involvement of administrators and staff at any or all stages in the process should be clearly negotiated and defined. The stages of the process are summarized in three diagrams.

1613. MCGRATH, B. J. and KOEWING, J. R. **A clinical preceptorship for new graduate nurses.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, March, vol. 8, no. 3, pp. 12-18.

The 258-bed Moore Memorial Hospital, Pinehurst, N.C., found that newly graduated nurses failed to meet the expectations of the administration and the medical and nursing staff. Following discussions with the area health education centre, a personalized clinical preceptorship programme was devised to smooth the transition from student to charge nurse. Four preceptors were chosen to guide the transition and serve as role models for 20 new nurses: a patient care co-ordinator for the intensive care unit; a staff nurse in the surgical intensive care unit; a staff nurse in the emergency room; and a part-time nurse working for a baccalaureate degree. Formal and informal evaluations of the programme and the performance of both preceptors and graduate nurses were conducted to determine the value of this approach. Preceptors, graduates, nursing and medical staff and administration believed the programme had been successful and should be offered again.

1614. Welche Ausbildungsinhalte haben sich in der beruflichen Praxis bewährt, welche nicht? **[Which parts of training have proved themselves in professional practice and which have not?]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, April, vol. 31, no. 4, pp. 159-161.

A newly qualified nurse, whose first job was in a department of obstetrics and gynaecology which had adopted the group nursing system, discusses how her training had helped her. She found that the basic training and practical work had been most useful but that her greatest difficulties were in dealing with the 'paper war' and in co-ordinating her duties with the staff working under her. She regrets that her clerical and organizing duties means that basic nursing care has to be delegated to others. Another nurse describes her experience at an 18-months post-basic course for nurse tutors. She found the instruction in teaching methods and psychology and the practical training to be well planned.

1615. BERGMAN, R. and others. **Multi-applications to nursing education programs in Israel: facts and issues.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 2, pp. 83-90.

The discrepancy in applications for nursing courses in Israel and the actual admissions gave rise to a study of: (i) applications for the year 1975 to 1976; and (ii) the selection criteria, priorities and processes of the nursing schools. A total of 1,764 applications were filed in the 14 schools from 1,375 candidates, 296 of whom had applied to more than one school. Of the 634 students who actually started to study in 1975, 175 were multiple applicants and 106 had not been rejected by any school. The majority had been accepted by one school only and 61 per cent were classed as very good or good students. Students who were frequently rejected gave a less good performance. The findings showed a considerable wastage of resources when candidates applied to more than one school. The authors recommend the establishment of a central registry for all schools, with the student indicating her preferences.

1616. PHILLIPSON, P. A. J. and GEDDES, N. **The reasons learners go absent.** *Nursing Mirror*, Sutton, 1978, June 8, vol. 146, no. 23, pp. 12-15.

Sickness data from learners working in a variety of wards in two hospitals in 1976 was collected and analyzed. Among the findings were: (i) a greater level of sickness among pupil nurses than among student nurses; (ii) the highest monthly figure was for March; (iii) the monthly variation was the same in both hospitals; (iv) the highest annual rate of sickness in both hospitals was in the children's wards; (v) the lowest rate was in the school of nursing; (vi) married students and pupils had higher rates than single ones; (vii) male students and pupils had less than half the rate of females; and (viii) vomiting and diarrhoea caused the greatest number of learners to be off sick, followed by coughs and colds and backache.

1617. KELLY, P. A. and LAMBERT, K. L. **The effect of a modified team approach on nurse-patient interaction and job satisfaction.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, April, vol. 8, no. 4, pp. 3-9.

At the Medical Center Hospital of Vermont, a system of team nursing was devised which assigned each patient to a team on the basis of the team's workload and the patients' needs. Team leaders were prepared by 15 to 20 hours of discussion of the team nursing concept and had overall responsibility for a group of up to 10 patients. The project was well accepted by the nurses, but in practice, the team depended too much on the leader and displayed a high degree of job dissatisfaction. As a result, after one year, the role of the team leader was evaluated by a review of the original job description. Despite difficulties among the staff, the project resulted in better communication between staff and patients. This was shown by the patients' ability to identify who was primarily responsible for their care and by an improved understanding of their treatment.

1618. REDFERN, S. J. **Absence and wastage in trained nurses: a selective review of the literature.** *Journal of Advanced Nursing*, London, 1978, May, vol. 3, no. 3, pp. 231-249.

The factors concerned with the two types of withdrawal from work in trained

British nurses, absence and wastage, are considered and grouped into three categories: person/personality, work context and external variables. There is no doubt from the literature that the frequency of absence spells, short-term absence or uncertificated absence, is increasing for nurses as well as for other workers and is giving managers more cause for concern than long-term absence (more than three days duration) or certificated absence. Present trends suggest that mobility is not excessive and may even be too low. This could present as great a problem to nurse management as excessive wastage if it results in a degree of 'in-breeding', 'stagnation' and 'complacency'. The optimum level of mobility is presumed to be one which strikes a balance between innovation, fresh ideas, etc., and a necessary cohesive core of staff. That optimum level is likely to vary between units and organizations.

1619. DEVINE, B. A. **Nurse-physician interaction: status and social structure within two hospital wards.** *Journal of Advanced Nursing*, London, 1978, May, vol. 3, no. 3, pp. 287-295.

This paper focuses upon how nurses' perceptions were influenced by their interaction with physicians, singling out both the stratification system within the hospital and the structure of the two wards as a major source of conflict. Physicians are viewed as being 'significant others' in the nurses' definition of self; consequently physicians involved in daily interaction with nurses, are included in order that their perceptions of the nurse's job may be seen to influence the perceptions which nurses have of themselves. An assumption, basic to this study, is that physicians are in a dominant position within the hospital and nurses are subordinates in the organization. A ward comparison viewed the relative power position of doctors at various levels in the medical hierarchy as affecting the amount of agreement and understanding that existed between nurses' and physicians' perceptions of the nurse's job.

1620. TREMBLAY, A. Contrôle de la qualité des soins infirmiers: exécution de techniques par le personnel infirmier. **[Control of the quality of care: nursing techniques considered.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 20-29.

A method of assessing how well nurses perform specific nursing techniques, such as taking the patient's temperature, is described, and the criteria on which it is based explained. The description is accompanied by five appendices: (i) assessment grid relating to taking temperatures; (ii) groups of techniques to be evaluated; (iii) report on control of quality of care in a centre of activity; (iv) plans for corrective action; and (v) a graph of the profile of quality of nursing care in a department, illustrating the results of three series of evaluations relating to techniques.

1621. BOYLE, M. A. and others. **The Doncaster system of audits for the nursing service.** (King's Fund Project Paper No. 18) London, King Edward's Hospital Fund for London, 1977, [i], 36pp. £0.50

The Doncaster Nursing Audit System attempts to supply a methodical review of the whole range of nursing activity within a defined health district. This report of the nursing audit system considers the history and various aspects including: the link with the Nursing Staff Appraisal System; methods of implementing the audit system; feed-back and monitoring of the audit system; philosophy derived from the evolution

of the nursing audit system; the objectives and future plans of the Doncaster Nursing Audit System. Six appendices are included which provide information on: unit time-table; record of interview dates; summary for each ward in unit; summary for Nursing Officers' use; summary for Senior Nursing Officers' use; and summary for Divisional Nursing Officers' use. A list of four references and details of audits currently available are included.

1622. JOINT WORKING PARTY OF THE REMEDIAL AND NURSING PROFESSIONS. **Report.** (Chairmen: Mr. E. L. McMillan and R. B. Mayoh) London, Royal College of Nursing, [1977], [iii], 6pp.

The Joint Working Party was set up in 1975 to discuss the present areas of overlap between the work of the nursing and midwifery and remedial professions, to set out guides to good practice in relation to both specialist and primary health care, and to make recommendations. The report considers: the problems of overlap; the need for teamwork, including resource limitation, communications and interaction; the specialty services; and the mutual skills required by nurses and therapists. Recommendations on good practice are presented covering: operational policy; communication; the need for consistency and continuity of treatment; team work; and the use of helpers. Separate recommendations cover special services such as mental illness hospitals, mental handicap hospitals, geriatric and psycho-geriatric services, day hospitals, maternity services, paediatric services and primary health care.

1623. MARSH, N. **Development of the undergraduate nursing course in the University of Manchester.** *Journal of Advanced Nursing*, London, 1978, May, vol. 3, no. 3, pp. 297-313.

The diploma course in community nursing was set up in the University of Manchester in 1959 and was a unique experimental course in nurse education in which nursing was taught as a university subject. It sought to provide a university education in nursing, also demonstrating that integration of hospital and community nursing was possible in the basic course. In 1964, at the end of the experimental period, the course was revised and better integration of practical experience achieved. The revised course became the prototype for a degree course and, in 1969, the first group of students graduated bachelor of nursing. Since 1972 the annual intake of students has been increased from 12 to 25, although this number has been exceeded (153 students in the years 1972-1976). Courses have also been developed for qualified and experienced nurses—a diploma in advanced nursing studies and a master of science degree course (nursing option). Since 1970, research fellows have been appointed, firstly in the department of social and preventive medicine, and secondly, since its inception, in the department of nursing.

1624. BELBIN, R. M. and TOYE, J. **Trainability tests and the recruitment of student nurses.** *Journal of Advanced Nursing*, London, 1978, May, vol. 3, no. 3, pp. 277-285.

A trainability test is a means of estimating the suitability of a candidate for a course of training. Grounds for assessment are provided by the construction of a learning task which replicates some key aspects of the skill to be learned and the procedure by which they might be acquired. Such a test, based on the learning of medical terms, was given to 129 student nurses at five London general hospitals. Lower test scores were

found to be associated with a high drop-out rate for UK nurses and it is assumed for them that the test was measuring a capacity relevant to performing satisfactorily on the course. Low-scoring overseas nurses, however, were less likely to leave than their UK counterparts. Discussion of the reasons for this includes reference to the lower wastage rates among overseas nurses, evidence about overseas nurses' attitudes towards completing the course, and the possibility that this test underestimated the potential of overseas candidates. Methods are considered for making the test as valid for overseas as for UK candidates.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1583, 1612, 1711, 1728

1625. BOOGERT, J. A. van. Enkele aspecten van de problematiek van het management in ziekenhuizen. **[Some aspects of the problems of hospital management.]** *Ziekenhuis*, Utrecht, 1978, June 21, vol. 8, no. 12, pp. 310-311.

The paper is the report of a speech by the President of the Netherlands Society of Hospital Economists (NVZE) at the Utrecht Annual Trades Fair. Non-profit seeking hospitals should be run as economically efficient business concerns. The development of Health Service regionalization, to be backed by legislation now before Parliament, will create problems for hospital managements. Its general effect will be centralization. Regional decision-making bodies with financial powers will take away some of the independence hitherto enjoyed by the hospital managements. Decisions have to be made on redistribution of resources, and rivalries between hospitals will continue, with pressures from medical and nursing staff for services and equipment. Questions will arise as to whether politicians or professional health service members should make the decisions. Less management responsibility carries the risk of less economic efficiency. Tensions will arise between a cost-conscious administration and medical specialists, who often benefit financially from expensive equipment, see economy as a threat against their freedom of practice and will use patients' interests as a lever. Managements will have to check the values of any investment and encourage co-operation wherever possible.

1626. BAUGUT, G. Möglichkeiten einer Differenzierung der Krankenhausakitvitäten und deren Bedeutung für die Krankenhauspraxis. **[Possibilities for differentiation between hospital activities and their significance for hospital practice.]** *Krankenhaus*, Stuttgart, 1978, May, vol. 70, no. 5, pp. 168-172.

This is a report on an investigation carried out in an attempt to determine to what extent minimal or day or night care for suitable patients could relieve the burden on the staffing and financing of normal hospital beds. The results show that 16.9 per cent (14.8 per cent in minimal care facilities and 2.1 per cent in day or night care) of in-patients could be cared for in this way. A further 7.8 per cent could be looked after at home. This differentiation of hospital treatment reduces average length of stay by about 1.5 days. There are great variations in labour and materials costs between different hospitals but, at a conservative estimate, the saving per case would not be less than DM 100. To be effective these measures must form part of a wider programme aimed at increasing hospital efficiency.

1627. CASAS, S. Reflexiones sobre los hospitales: como instituciones o empresas no lucrativas. **[Thoughts on hospitals as institutions or non-profit-making establishments.]** *Policlinica*, Barcelona, 1978, May, no. 46, pp. 22-26.

The author compares and contrasts the hospital and the business enterprise. Their objectives differ but their means may be the same. The public or non-profit-making private hospital should not make a profit but it should not be expected to run at a loss, particularly if greater efficiency in operation can enable it to cover its costs. Although in general the objectives of the hospital and business enterprise are different, one objective common to both is the reduction of unnecessary expenditure and waste. The hospital can achieve this by, for example, reducing the length of time the average patient spends in hospital, or by eradicating one type of illness.

1628. KLINGLER, J. and SCHNEYDER, G. Das Organisationshandbuch—ein Mittel für die Betriebssteuerung im Krankenhaus. **[The organization manual—a method of controlling operations in hospitals.]** *Krankenhaus Umschau*, Kulmbach, 1978, April, vol. 47, no. 4, pp. 236-238.

The organization handbook can play an important part in the initiation of new members of the hospital staff and as a permanent work of reference. There should be separate handbooks for each department and service: this can mean anything between 20 and 50 handbooks depending in the size of the hospital and the services it offers. The contents of the handbook should include the following: a description of the duties and objectives; structure; organization; guidelines and regulations; equipment and its care; lists of materials, etc.; copies of standard forms; and a space for notes. So that it can be kept up to date the handbook should be in loose leaf form. A working group, on which all the main staff groups are represented, should be responsible for the production of the handbooks.

1629. BIDER, R. Voraussetzungen für die Durchführung von Kaderkursen. **[Prerequisites for the organization of management courses.]** *Veska*, Aarau, 1978, April, vol. 42, no. 4, pp. 187-191.

This paper is based on the 'Manual of leadership training at the Zürich University Hospital' and gives a detailed account of the courses which are organized. The basic course lasts 10 days (five days for doctors) and there are two-day refresher courses each year for leaders in all departments. During the four year period 1974-1978, about 250 staff members took the 10-day basic course and 100 attended the two-day refresher course. The total cost (excluding the continuing payment of salaries to those taking part) works out at about 100 Swiss francs per training day. While such a training system can be carried by a single large hospital it should be possible for a few small or medium-sized hospitals to run a joint course.

1630. SCHÄFER, G. Die Auswirkungen der Novellierung des Krankenhausfinanzierungsrechts auf den Krankenhausbetrieb. **[The effects of the amendment of the hospital finance law on hospital management.]** *Krankenhaus Umschau*, Kulmbach, 1978, May, vol. 47, no. 5, pp. 324, 327-329.

The author, a hospital administrator, presents a critical appraisal of the proposed amendments to the West German Hospital Financing Act of 1972. He concludes that the aim of the legislators is increased State regimentation of hospitals and considers this to be the wrong policy.

1631. **Administrative reviews.** *Hospitals*, Chicago, 1978, April 1, vol. 52, no. 7, pp. 58-168. (whole issue)

This special issue is devoted to reviews of developments in the United States in 1977 in the fields of: ambulatory care; capital financing; community relations; continuing health care; cost containment; education and training; government regulation; information systems; staff relations; management engineering; multi-institutional arrangements; planning; press comment; quality assurance; risk management; technology; and voluntary service. Each paper includes a list of references from the relevant literature.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 1594, 1599, 1636, 1667, 1671, 1723

1632. DEZSY, J. Neuorientierung des Krankenhauswesens aus wirtschaftlicher Sicht. **[Reorienting the hospital system from an economic point of view.]** *Krankenhaus Umschau*, Kulmbach, 1978, March, vol. 47, no. 3, pp. 142-145.

Hospital services and their costs are influenced by a number of factors. These include: science and technology; population and patients; the labour market and hours of work; health insurance; the system of society and the health system; and politics. All these factors are briefly examined. It is important that hospitals are used only when their services are essential and that other health services, such as general practice, are used to the best advantage. A restructuring of hospital services with the objective of limiting costs while retaining necessary performance requires, among other things, a change of attitude on the part of politicians as well as on the part of the public, to moderate demand.

1633. GRAG, M. L. and others. **Evaluating inpatient costs: the staging mechanism.** *Medical Care*, Philadelphia, 1978, March, vol. 16, no. 3, pp. 191-201.

In-patient records at a short-term hospital over two years were analyzed according to the stage or degree of severity of their discharge diagnosis to examine the patients' utilization of services. Patients with a more severe disease stage for surgical and medical conditions generated substantially higher total charges, ancillary charges, and had longer lengths of stay. At the 75th percentile (representing that value at which three-quarters of the cases fall below it in magnitude), increases in total charges from stage one to 11 for ulcer of stomach, appendicitis and diverticulitis were 103, 168 and 110 per cent, respectively. Ancillary charges for these diseases shared even greater increases, 167, 200 and 160 per cent, respectively. Components of ancillary charges revealed similar trends. The results suggest that a two-fold review mechanism incorporating length of stay and charges, using the staging techniques, would make the review procedure more discriminating in identifying cases appropriate for review.

RUNNING COSTS

See Abstract No. 1694

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1707, 1722

1634. DEVLIN, H. B. **Planned early discharge.** *Medical Record and Health Care Information Journal*, Truro, 1978, Feb., vol. 19, no. 1, pp. 364-366.

A planned early discharge system has been effectively put into use for routine surgical cases at the North Tees General Hospital. The system must be very carefully planned with the co-operation of all the departments involved and the conditions to which it is applicable must be defined. Patients are mobilized as soon as possible after their operation and discharged under the care of domiciliary nurses. Such a system has great advantages: for the patient, it permits advance notice of admission and early discharge home; and for the health service, it reduces costs and waiting lists.

1635. ASSMANN, K. and others. Theoretische und experimentelle Untersuchungen zum degressiven Pflegasatz. **[Theoretical and practical studies on the degressive cost per patient day.]** *Krankenhaus Umschau*, Kulmbach, 1978, March, vol. 47, no. 3, pp. 152-156.

Five formulas for determining average length of stay are given and it is shown that the figures obtained can vary by almost a whole day—in the Federal Republic of Germany this could represent a difference of more than DM 1,500m a year. In determining cost per patient day three types of costs are distinguished: (i) fixed costs; (ii) variable costs (of diagnosis and treatment); and consequential costs (of nursing and hotel services). The various types of costs are discussed and a model developed for their determination. As an experiment the records of 50 patients at an ante-natal hospital were examined in detail and costs determined for each day of their stay up to a maximum of 20 days. The average variable costs per day were then set out in a graph: this shows the expected peak on the days immediately after admission with troughs at each weekend. It is recommended that a further study should be made covering 700 patients for a four-week period. It is pointed out that a reduction in costs of supplies can only be achieved if a shorter length of stay is coupled with a reduction in nursing capacity.

APPOINTMENT SYSTEMS, WAITING LISTS

1636. SEELOS, H.-J. Patient-scheduling—ein Weg zur Kostendämpfung? **[Patient-scheduling—a way to reduce costs?]** *Krankenhaus Umschau*, Kulmbach, 1978, May, vol. 47, no. 5, pp. 339, 342-343.

The aim of a patient scheduling system (PSS) is to reduce waiting times to the absolute minimum and ensure that hospital resources are fully used. The basic questions on diagnostic and treatment procedures which a PSS must answer are: which patient; when; where; in what manner; and by whom. The system can work within a hospital information system and can either be computer-based or function through simple organizational measures. The basic principle is that all communication between different departments and services takes place through a central point. It is estimated that even if the average reduction in waiting time was only 15 minutes per patient, the saving per day on 100,000 out-patients' loss of working time would amount to DM 183,249.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 1639, 1644, 1686, 1692, 1698

1637. BAUGUT, G. and THIEL, K. Möglichkeiten und Grenzen der Rationalisierung im Bereich der Versorgung und Verwaltung. **[Possibility and limits of rationalization in the field of supply and administration.]** *Krankenhaus Umschau*, Kulmbach, 1978, March, vol. 47, no. 3, pp. 146-148.

This is a survey of the uses of electronic data processing in the fields of hospital administration and hospital supplies. Under administration is included: patient admissions; performance records; accounting (including cost accounting); and information systems. Under supplies is included: drug administration; stores records; and ordering. Examples are given which show that the economics of electronic data processing in hospitals cannot be determined on the basis of cost per patient day alone. Future possibilities for electronic data processing in hospitals are discussed.

LIBRARIES

See Abstract Nos. 1645, 1686

ORGANIZATION AND METHODS, WORK STUDY

See also Abstract No. 1722

1638. PAPAGEORGIOU, J. C. **Some operations research applications to problems of health care systems (a survey).** *International Journal of Bio-Medical Computing*, Barking, 1978, March, vol. 9, no. 2, pp. 101-114.

In this paper, a brief survey of operations research applications to problems of health care systems is made. It shows the possibilities which exist for improving the design and operations of hospitals and other health care systems through the use of operations research. The different applications have been divided into groups, but it should be noted that there is a great deal of overlapping.

MEDICAL RECORDS

1639. ROUSE, J. D. **Hospital computer registration system with community links.** *Medical Record and Health Care Information Journal*, Truro, 1978, Feb., vol. 19, no. 1, pp. 349-358, 361.

The Exeter Community Health Services Computer Project has implemented a real-time computing system which combines in a single Integrated Patient Record (IPR) data originating from: (i) general practitioners; (ii) hospital; and (iii) service departments. This paper describes in detail the hospital system, involving two hospital groups: (i) the Royal Devon and Exeter Hospital; and (ii) the Princess Elizabeth Orthopaedic Hospital, each with its own case note numbering system. A visual display unit is used for registration of patients, and identification details and extension displays,

available by use of various keys, give further information. The patient summary gives all administrative information on a patient and a termiprinter provides labels for case notes, etc. The master patient index provides a cross reference between the patient's surname and his computer number, and supplies index lists. Other systems are being developed, but the registration scheme is economically viable on its own and is of great benefit to the records department.

1640. DOMANICO, L. and LEVERETTE, T. J. **Shared project studies, revises hospital record retention policies.** *Hospitals*, Chicago, 1978, May 16, vol. 52, no. 10, pp. 133, 134-136.

Through MediSHARE, their not-for-profit shared service organization, six hospitals in the San José, California area conducted a study that showed that they had similar practical needs and legal requirements for medical record retention, but widely varying retention policies. As a result written policies were developed and adopted jointly by the hospitals; these have ensured consistent cost-effective retention practices. The existing practices at the six hospitals and the new common policy are summarized in three tables.

1641. Ross, E. Drei Jahre Mikroverfilmung von Röntgenaufnahmen bei Integration in den diagnostischen Betrieb. **[Three years microfilming of X-rays and their integration into the diagnostic process.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Feb., vol. 19, no. 2, pp. 100, 103-108.

The principles and practice of microfilming X-ray photographs are described and evaluated on the basis of three years' experience in a West German hospital. The integration of this procedure into the diagnostic process involves three main factors: immediate filming of photographs; immediate handing over of the original, (a) in the case of an out-patient, to the patient himself for passing on to the referring doctor, and (b) in the case of in-patients, to the clinical department; and examination of the primary microfilm positive by the radiologist who sends a written report to the referring doctor who has already seen the original X-ray. The whole process is described in detail, with illustrative diagrams, and it is shown that with 130 patients and 650 micro-photographs per day there is a saving of DM 1,526 a month over a conventional X-ray system. In addition there is a saving of one staff member and 46 sq.m. of space.

1642. FRANKE, H. Mikroverfilmung im Krankenhaus. **[Microfilming in hospitals.]** *Krankenhaus Umschau*, Kulmbach, 1978, April, vol. 47, no. 4, pp. 228-230, 235.

Since 1971 the 1,000-bed Katharinen Hospital, Stuttgart, has preserved medical records and X-ray photographs in their original form for three years and has then microfilmed them. Details are given of the organization of this work, the problems involved, the equipment necessary, and the costs. While it is shown that, over a 30 years period, the cost of microfilming records and X-ray photographs after three years would cost more than retaining them in the original form, the saving of space and easier retrieval must be taken into account. It is concluded that, in a large hospital, microfilming is a simple and reliable method for the storage of records.

1643. SCHEFFEL, W. Mikrofilmanwendungen im Gesundheitswesen. **[Uses of microfilm in the health system.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Feb., vol. 19, no. 2, pp. 89, 90, 93.

This paper presents in summary form the possible applications of microfilm in the health services under the following heads: financial administration; patient records; X-rays; recording of patient data (e.g., ECG and EEC); documentation; research and education; other areas.

1644. DUDECK, J. Ein Ordnungssystem für Mikrofiches von Patientenakten mit computerunterstütztem Retrieval. **[A filing system for microfiches of patients' records using computer-supported retrieval.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Feb., vol. 19, no. 2, pp. 93, 94, 96-99.

The author describes the three main systems for the storage of patients' records on microfilm. They are differentiated by the method of selection and are as follows: manual selection; machine selection; and computer-based selection with direct presentation. The two computer-based systems described are SYNELEC, which is microfiche-oriented, and DATAVISION which involves maximum reduction on what is called an 'ultrastrip' which can take 2,000 A4 size pages.

1645. Mikrografische Informationssyteme. **[Micrographic information systems.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Feb., vol. 19, no. 2, pp. 87-88.

The following are the main advantages of microfilm: documents of differing sizes appear in a uniform, small format; documents can be arranged in a fixed order; microfilm can be copied quickly, simply and economically; and the photographic record is true to the original. The disadvantage against paper is that the possibility of extending or amending a record is limited; another disadvantage is that without a computer, selection regrouping of records is not possible. Microfilm will never replace paper or the computer but can improve the efficiency of both. A brief note on the various types of microfilm readers is included.

HOSPITAL STATISTICS

See also Abstract No. 1699

1646. NAEGELE, I. Die neueste Krankenhaus-statistik (31.12.1976). **[The latest hospital statistics. 31.12.1976.]** *Krankenhaus*, Stuttgart, 1978, May, vol. 70, no. 5, pp. 179-186.

The West German hospital statistics as at 31 December 1976 are presented in a series of tables, with a commentary. There were 3,436 hospitals (53 per cent public, 35 per cent owned by charitable organizations, and 12 per cent private) with 726,846 beds: there were 118.3 beds per 10,000 inhabitants. Of a total staff of 702,242, there were 62,301 doctors (12.3 per cent from overseas), 247,642 nurses, excluding students (3.4 per cent from overseas), 49,776 administrative staff (2.3 from overseas) and 187,195 domestic staff (0.3 per cent from overseas). There were 10.7m in-patients with an average length of stay of 21.5 days (16.3 days in acute hospitals) and an average bed occupancy of 82.6 per cent.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1630, 1640, 1657, 1729

1647. WEIR, R. F., editor. **Ethical issues in death and dying.** New York, Columbia University Press, 1977, xxi, 405pp.

This collection of 26 articles written by people in the life-sciences, law, medicine, philosophy and religion maintains that a juxtaposition of fear and fascination is evident in the attitudes of individuals when death is discussed or relationships with the terminally ill are undertaken. However, neither of these attitudes helps to resolve the complex issues that frequently confront terminal patients and their families. Aspects discussed include: truth telling; determining death; euthanasia; allowing to die; and suicide. References are given after each chapter and an author/subject index is included.

1648. GIROUX, F. **Why hospitals need security systems.** *Dimensions in Health Service*, Toronto, 1977, Dec., vol. 54, no. 12, pp. 26, 28-29.

A well-integrated security system is becoming increasingly necessary for the safe and efficient operation of a hospital. The security function must be well organized under a professional security person, responsible to a senior hospital administrator. The two security systems preferred in Canada are contracted security and in-house security, the latter rarely being successful in an institution with unions. Adequate training of security officers is vital, including courses in the law relating to security. The duties of the security department should include: (i) control of the locking systems; (ii) control of internal and external traffic; (iii) fire and safety detection and prevention; (iv) control over lost property; and (v) liaison with outside agencies such as the police, the fire service and the disaster planning co-ordinator.

1649. WHINCUP, M. H. **Legal aspects of medical and nursing service: a guide to employment rights and practitioners' duties.** 2nd edition. Beckenham, Ravenswood Publications, 1978, xxi, 88pp. £6.50

This enlarged and revised volume is intended to give hospital and health service staff, especially doctors and nurses and also those in the occupational health services, such information on the legal aspects of their duties 'as may help them to do their work correctly and with confidence'. The rights of the professional man or woman as an employee are outlined, followed by various aspects of safety of employment, a review of legal rulings on misadventure and negligence in diagnosis and treatment, as well as guidance on advisory duties, the role of confidentiality and appearance in court. A table of statutes and list of cases mentioned in the text are included.

1650. FRIEDMAN, E. **'Natural death' laws cause hospitals few problems.** *Hospitals*, Chicago, 1978, May 16, vol. 52, no. 10, pp. 124, 126, 128-130, 148.

By 1 April 1978, eight states in the United States had passed laws covering a patient's right to die; legislation was under consideration in a number of others. This review of the existing legislation and experience with its application shows that, with the exception

of a very few minor problems, hospitals in the eight states report no difficulties and few changes in their procedures as a result of the new laws. Most hospital association activities have centred on the education of member institutions about the content of the legislation.

OTHER SPECIAL ASPECTS: MERGERS

1651. **Beleidsalternatieven bij fusies van ziekenhuizen. [Alternative types of merged hospitals.]** *Ziekenhuis*, Utrecht, 1978, June 7, no. 11, pp. 290-291.

The paper discusses the phase prior to a decision to merge and includes a planning model. According to a report on 10 hospital mergers half of the negotiations had been poorly conducted. This could be improved by a code of conduct backed by legislation, more staff influence, greater responsibility by all parties and occasional assistance by neutral third parties. The starting point of merger planning should be willingness to negotiate. This can be preceded by determination of strategy, informal talks, etc., followed by a discussion on merits, conditions and alternatives. Next comes an investigation in location and aims, thus establishing an image of the future hospital. The next stages comprise an enquiry into how to handle the merger and a list of practical steps to be taken, producing an action plan. Finally there must be research into the social implications, including legislation, and consultation with staff and trade unions. Research into the motives for mergers revealed diverse reasons such as: reductions in beds, building and running costs; better service quality; avoidance of competition; and better working conditions, none of which were in themselves sufficient grounds for a merger. Alternatives could be forms of collective co-operation. Before deciding on a merger, questions should be answered on its effect on the motives, costs and the capability of managements to cope with the changes. The paper includes a diagram of the phase.

FINANCE AND ACCOUNTING

See Abstract Nos. 1630, 1659

FINANCE

See also Abstract Nos. 1633, 1636, 1680

1652. BELAND-BACON, J. Encadrement de la fonction contrôle: les méthodes. **[The framework of managerial control: methods.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 88-93.

The author demonstrates the importance of evaluation in the management of an enterprise. The budget serves as a basis for evaluation of performance, since it establishes what is expected from each employee so that predetermined objectives can be obtained. Deviations from the predicted budget are analyzed so that any necessary correctives can be introduced. Deviations from standard costs are also measured.

The role of evaluation in determining the level of investment and the expected return on investment is also explained. Four diagrams summarize the arguments.

1653. BLOUIN, R. Le contrôle budgétaire. **[Budgetary control.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 82-87.

The author proposes a simplified model for budgetary control in the individual care unit; it is based on the numbers of hours worked by staff and the extent to which these deviate from a predetermined level. The workings of the model are illustrated with eight figures.

1654. LASH, M. P. **Developing and implementing a personnel budget report.** *Hospitals*, Chicago, 1978, May 16, vol. 52, no. 10, pp. 111-112, 114.

Attempts to contain rising costs are dependent on a sound management information system, an essential component of which is a personnel budget report. This paper offers some practical insight into the general issues to be decided in developing a personnel budget report. The stages in its development include: (i) identify managerial responsibility for each area within the hospital; (ii) determine the limit of production for each area; (iii) develop a weighting or relative value system in order to count accurately the variety of production limits within a department; (iv) identify the key management indicators to be used in an operational analysis; (v) establish acceptable production standards; and (vi) decide upon an exception reporting programme for the chief operating officer. Experience in the development of the system at the Ohio State University Hospitals is outlined.

1655. SCHRIJVERS, G. and ZUIDBERG, J. Wat weten en vinden patiënten en zorgverleners van de kosten van de gezondheidszorg? **[What do patients and staff know and think about health care costs?]** *Ziekenhuis*, Utrecht, 1978, June, vol. 8, no. 12, pp. 320-324.

The first article deals with the setting up of the investigation and its findings among hospital staff. During the autumn of 1977 seven medical students interviewed some 150 staff members of a general hospital and some 150 patients on cost awareness of the Health Services. The investigation was prompted by the Government's desire to stimulate cost awareness among the public, the apparent greater consumption of health care service in the public than in the private sector and the encouragement of patients to become more involved in their own health care. The present aim of the authorities is a reduction in cost increases, and tensions are often created in trying to maintain a balance between these aims and the wishes of patients and those employed in the Health Services. Three questionnaires were issued to out-patients, in-patients and staff members respectively. It was found that among the staff half of the direct questions were answered correctly, 42 per cent knew that most hospital funds went on staff salaries and that most Health Service funds went to hospitals. Suggestions for spending more money (150) exceeded those for spending less (82). Two thirds thought there was insufficient communication and co-operation between groups within the hospital and between the hospital and extra-mural services. One third thought some of the work unnecessary. Some 17 per cent had no opinion. More details are given with figures and percentages.

1656. BLUMBERG, M. S. and GENTRY, D. W. **Routine hospital charges and intensity of care: a cross-section analysis of 50 states.** *Inquiry*, Chicago, 1978, March, vol. 15, no. 1, pp. 58-73.

The basic premise of this paper is that a major determinant of average hospital cost per patient day is the volume of services patients receive per day. The weighted volume of services received per patient day is defined as the 'intensity' of care. Five major mechanisms contribute to intensity of care: patient disease or procedure; patient status; medical and nursing practices; length of stay; and hospital admission rate. The results of a cross-section analysis of data from each of the 50 states in the United States largely support the central hypothesis that states with greater intensity of care have higher routine costs per patient day. In a cross-section multiple regression model, an increase in admission rates and in average length of stay reduced the cost per day. This affirms the contention that the intensity of services provided, even if they are 'routine' services, is an important determinant of costs per day. The implications of the findings are discussed.

1657. PIERONI, D. T., editor. **Physician compensation.** *Topics in Health Care Financing*, Germantown, Md., 1978, vol. 4, no. 3, pp. 1-138.

The intention of this issue is to present the basic concepts of physician compensation in the United States with sufficient technical detail to give a perspective on the complexity of the subject. No conclusions are drawn nor recommendations made. The individual chapters cover: an overview of physician compensation; hospital-based physician compensation concepts; the impact of physician compensation arrangements on hospital financial management; third party reimbursement aspects; tax considerations; the regulatory environment; and medical practice plans. Included as appendices are the American Hospital Association guidelines on contractual arrangements between hospital and physicians and a list of factors that indicate control.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1658. MACPHERSON, E. **How to maintain standards within reduced budgets.** *Caterer and Hotelkeeper*, London, 1978, May 25, vol. 168, no. 3,013, pp. 51-53, 55, 57.

This paper examines the ways in which hospital catering managers in Great Britain have been striving to maintain standards and improve their image as senior hospital managers in the face of financial restrictions. The hospitals discussed are: (i) Bethlem Royal, a psychiatric post-graduate teaching hospital, which is one of the few National Health Service hospitals still employing an outside contractor; (ii) St. George's Hospital, London, under threat of closure and 'operationally difficult' as far as catering is concerned; and (iii) Southampton General Hospital, a new and still developing teaching hospital.

LAUNDRIES AND LINEN SERVICE

HOSPITAL LINEN AND TEXTILES

1659. ANTHONY, M. F. and WILSON, G. **Costly materials retrieved from laundry chutes.** *Hospitals*, Chicago, 1978, May 16, vol. 52, no. 10, pp. 119-120, 122.

As part of an examination of the whole process of supply from vendor to user, a study team at Johns Hopkins Hospital, Baltimore, found that less than 70 per cent of medical and surgical instruments issued to clinical areas were returned for sterilization and re-issue. Increased security had little effect on the loss. After the director of linen service remarked on an increase in loose instruments at laundry collection points, it was found that an inordinate number of instruments were being removed from the linen received at the co-operative laundry used by the hospital. All such instruments discovered there were pooled and disposed of with only minimal recovery of their value. The hospital staff now visit the laundry weekly to identify its instruments from those put aside by the laundry staff. During the first year of this programme, instruments, etc. worth $22,352 were recovered.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

See Abstract No. 1664

HYGIENE IN THE HOSPITAL

1660. WIDMER, H.-R. Das Hygienewesen am Inselspital aus der Sicht des Spitalhygienikers. **[The system of hygiene at the Insel Hospital (Berne) from the point of view of the hospital hygienist.]** *Veska*, Aarau, 1978, April, vol. 42, no. 4, pp. 185-186.

The Insel Hospital, Berne, has a standing hygiene committee with the following membership: the deputy hospital director; the chief pharmacist or hospital hygienist; a surgeon; a physician; four senior nursing officers; the domestic superintendent; the engineer; and (in an advisory role) the hygiene nurse and the disinfection officer. Some of the committee's duties and powers are delegated to a five-member subcommittee. Initially the committee carried out a thorough survey of the hygiene of all departments. Up-to-date information on pathogenic micro-organisms is received weekly from the Institute of Hygiene and Microbiology and the presence of such micro-organisms in patient material is tabulated. Among the subjects on which instructions have so far been issued by the committee are the following: kitchen hygiene; prevention of Salmonella outbreaks in milk kitchens; disinfection after septic operations; disinfection of sputum, pus, blood secretions and rinsing fluids; disinfection in hepatitis; and the prevention of explosions when disinfectants containing alcohol

are in use. It is estimated that in spite of measures so far taken, hospital infections cost the Insel Hospital 1.7m. Swiss francs a year (for a total of 22,000 patients).

HOSPITAL INFECTIONS

1661. MYERS, M. G. **Longitudinal evaluation of neonatal nosocomial infections: association of infection with a blood pressure cuff.** *Pediatrics*, Evanston, Ill., 1978, Jan., vol. 61, no. 1, pp. 42-45.

Nosocomial infections acquired in a special care nursery of the University of Iowa Hospitals, Iowa City, were surveyed longitudinally. The rates of acquired infection were determined allowing the evaluation of specific infection control measures. A blood pressure cuff, used for all infants in the nursery, was associated with an increased rate of infection.

SOURCES OF INFECTION

See Abstract Nos. 1661, 1695, 1703

PREVENTION AND CONTROL

See also Abstract Nos. 1665, 1693, 1705

1662. VOGL, J., WUNDT, W. and OELLERS, B. Untersuchungen über die Wirksamkeit eines Trockenmattensystems zur Verminderung der Keimzahlen auf Fussböden infektionsgefärdeter Bereiche. **[Investigations on the effectiveness of a dry matting system in reducing the germ-counts on floors in areas threatened with infection.]** *Krankenhaus*, Stuttgart, 1978, May, vol. 70, no. 5, pp. 195-197.

Experiments have been carried out with a proprietary dry mat product called 'S-entry' to determine its efficacy in reducing the microbial counts on floors in aseptic areas. 'S-entry' has a light metal framework containing the mat which consists of 20 individual layers of polyethylene foil, impregnated with the antimicrobial substance benzisothiazoline, to which impurities adhere. The mat is cleaned by simply removing the soiled top layer of foil. Laboratory experiments and experiments under clinical conditions have shown that while contamination of the soles of shoes and of castors is reduced this reduction is not sufficient to justify the cost of the mats.

1663. DIETZEL, W. Angewandte Hygiene zur Infektionsprophylaxe in der Intensivtherapie. **[Applied hygiene for the prevention of infection in intensive care.]** *Krankenhaus*, Stuttgart, 1978, May, vol. 70, no. 5, pp. 191-194.

Because of the lack of resistance of critically ill patients and the type of treatment necessary in intensive care units, the risks of infection are enhanced. Measures to prevent infection are therefore of paramount importance and this paper outlines those necessary in relation to the following procedures: endotracheal intubation; bronchial cleansing; respiration and inhalation therapy; infusion treatment; intra-

vascular catheterization; feeding by tube; puncture and drainage of body cavities; and catheterization of the bladder. Stress is laid on the importance of hand disinfection before and after carrying out procedures and of the changing of clothing. It must be borne in mind that the most important and most dangerous source of infection in an intensive care unit is the patient.

1664. GRASSI, R. and VANINI, G. C. La disinfezione in ospedale: risultati di una indagine circa le modalità di impiego dei disinfettanti. **[Disinfection in the hospital—results of an investigation into the methods of using disinfectants.]** *Ospedale*, Torino, 1978, April, vol. 31, no. 4, pp. 83-87.

A questionnaire was sent to 206 hospitals and nursing homes in Piedmont in order to discover what methods were employed for the disinfection of floors, surfaces, the atmosphere, beds, operating fields, instruments, hands, excreta, linen, etc. Only 46 responded. Analysis of the responses showed that quaternary ammonia compounds are the products of choice for every type of disinfecting process. Iodophores, chlorhexidine, and phenol compounds are relatively little employed. Ethyl alcohol is still widely used for disinfecting beds, wounds, and skin, despite the fact that its limitations have been emphasized repeatedly. A wide range of substances, some of doubtful value, some useless, and some harmful, is in use. The findings are summarized in 21 tables.

HYGIENE IN THE OPERATING THEATRE

1665. LINDBERG, L. and STRINDEHAG, O. Partikel- och bakteriehalt i specialbyggda operationsrum. **[The particle and bacterial count in a specially constructed operating theatre.]** *Sjukhuset*, Göteborg, 1978, vol. 55, no. 2, pp. 181-182, 185-186, 188.

Measurements carried out in the department of orthopaedic surgery at Lund Hospital demonstrate that it is possible to reduce the airborne particle and bacteria counts significantly by means of a specially constructed operating theatre. The 'operating box' installed in the operating theatre ensures a vertical (downward) flow of triple-filtered air. Instruments are passed in and out through special openings in the glass walls, and theatre staff wear special uniforms comprising ultra-protective clothing and helmets. Air is extracted at floor level and leaves the theatre by the normal extractor duct system. The box is entirely self-contained and requires no special connections to floor, walls or ceiling. Light fittings are mounted outside the box so as not to disturb the laminar airflow. Two independent fans drive the air through an F95 filter and a HEPA filter (99.996 per cent efficiency), at a rate of 3 m^3/s, or 500 changes of air an hour. Numbers of particles greater than 0.5 um in size are 1.4×10^3 on average, compared with $2{,}700 \times 10^3$ in a conventional operating theatre, whilst the number of colony-forming bacteria collected in three separate investigations was nil. Average numbers of bacteria outside the box were 46; in a conventional theatre 218, and in the corridors 961. The article is illustrated with a schematic cross-section of the box, two photographs of it in place, a plan showing where counts were taken, and tables and a graph showing bacterial and particle counts at different sites in the hospital.

STERILIZATION

See also Abstract No. 1660

1666. SANGER, R. G., BRADFORD, B. A. and DELANEY, J. M. **An inquiry into the sterilization of dental handpieces relative to transmission of hepatitis B virus.** *Journal of the American Dental Association*, Chicago, 1978, April, vol. 96, no. 4, pp. 621-624.

Evidence for the transmission of hepatitis B virus in dentistry is presented. The dental profession should be keenly aware of aseptic clinical techniques and effective sterilization procedures. Some dental handpieces can be damaged by conventional sterilization procedures. Alternatives are discussed. A review of currently available handpieces and their appropriate sterilization process is presented.

DISPOSAL OF WASTE

See also Abstract No. 1659

1667. ANNA, O. and KLIE, H. Beseitigung infektiöser Abfälle in Krankenhäusern —ein Vorschlag zur wirtschaftlichen Lösung. **[The removal of infectious waste in hospitals—a proposal for an economic solution.]** *Krankenhaus Umschau*, Kulmbach, 1978, March, vol. 47, no. 3, pp. 171-172.

Hospital waste divides into three categories: normal waste; special waste such as human organs or animal cadavers; and what is called 'problem waste', i.e., infectious materials such as plastics and glass. It is proposed that small hospitals should replace their incinerators by sterilizers, sterilize their 'problem waste' (which is then disposed of as normal waste) and transport human organs and animal cadavers to larger hospitals where they would be incinerated. Large hospitals would sterilize 'problem waste' for disposal as normal waste and continue to incinerate human organs and animal cadavers.

SAFETY MEASURES

ACCIDENTS, GENERALLY

1668. Az egészségügyi dolgozók üzemi baleseti helyzete 1966-1975 között. **[Work accidents of health personnel 1966-1975.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1978, March, vol. 16, no. 1, pp. 53-59.

The number and rate of accidents in the health facilities rose during the third and fourth five year plan (1966-1975) when compared with the previous period to a small degree. This increase characterized the first five years. However as a result of numerous measures a further deterioration did not take place during the second five years. Most accidents occurred amongst the trained health workers (nurses, etc.) and the manual workers. It is necessary to attach greater importance to this problem in the health facilities.

CIVIL DEFENCE IN THE HOSPITAL

1669. MUMENTHALER, H. Le service sanitaire de la protection civile—collaboration avec les hôpitaux. **[The civil defence health service—collaboration with hospitals.]** *Veska*, Aarau, 1978, Feb., vol. 42, no. 2, pp. 77-80.

The 1971 Swiss plan for civil defence health services envisaged four types of medical units: (i) 'protected operation' centres (COP); (ii) emergency hospitals (HS); (iii) emergency medical posts (PSS); and (iv) medical posts (Po San). COPs, (always attached to a hospital), are a cantonal responsibility while the three others come under the central civil defence authority. The aim is to provide one COP or HS for every 30,000 inhabitants, one PSS for every 15,000 to 20,000 inhabitants, and one Po San for every 400 to 500 inhabitants: this would give a total of 140,000 civil defence hospital beds. At present 40 per cent of COPs or HSs, 55 per cent of PSSs and 35 per cent of Po Sans have been constructed but distribution throughout the country is very uneven. Details are given of the advance arrangements to be made in times of peace and of procedures to be carried out when there is a general mobilization of the army.

PLANNING FOR MASS EMERGENCIES

1670. ZEILE, G. Grundzüge der madizinischen Katastrophenabwehr in Kliniken und Krankenhäusern. **[Basic features of medical catastrophe prevention in private and public hospitals.]** *Krankenhaus*, Stuttgart, 1978, May, vol. 70, no. 5, pp. 172-176.

These recommendations for a hospital disaster plan are based on the plan of Mainz University Hospital. Four types of disaster are distinguished: mass casualties; mass poisoning; radiation accidents; and smallpox or similar serious infections. Three different levels of severity are recognized: 10 to 20 victims; 20 to 50 victims; and over 50 victims. Details are given of the advance arrangements necessary for each type of disaster and for each level of severity. A large hospital should be able to allocate up to 20 per cent of its bed capacity for disaster victims either by discharging patients able to walk or transferring them to other hospitals or institutions.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract Nos. 1683, 1714, 1717

1671. BRUSA, A. and others. Indagine campione in un ospedale general regionale sui ricoveri per valutare la domanda dei servizi sanitari atti a contenere il numero di quelli non indispensabili. **[Sample survey in a regional general hospital on admissions to assess the demand for health services with a view to restricting the number of the essential services.]** *Ospedale*, Torino, 1978, April, vol. 31, no. 4, pp. 89-93.

A questionnaire completed by each doctor in a Turin hospital for each patient

discharged by him during a two-week period, asked him to state whether, in his opinion, the patient had required treatment in an acute hospital or not, and if not, whether he should have been treated in a day hospital, out-patient clinic, convalescent home, long-stay hospital, rehabilitation centre, or at home. Replies relating to 2,159 patients were obtained. In the doctor's opinion, 17.56 per cent had not required treatment in an acute hospital; the majority of these should have been treated in a day hospital or out-patient clinic. It also appeared that the patients in this category spent 14.5 days in hospital as compared with 17.1 days for those for whom hospital treatment was considered to be indispensable. The implications of these findings are discussed and the details are summarized in seven tables.

WELFARE OF THE PATIENT

See also Abstract Nos. 1617, 1650, 1681, 1702, 1712, 1716, 1725, 1730, 1734

1672. REYNOLDS, M. **No news is bad news: patients' views about communication in hospital.** *British Medical Journal*, London, 1978, June 24, vol. i, pp. 1673-1676.

One hundred patients on four general surgical wards at Bristol Royal Infirmary were interviewed about the information they had received about their illness and what they had been told about the investigations they had undergone. Fifty-five of them expressed some dissatisfaction and 14 were strongly dissatisfied. The way in which ward rounds were conducted was heavily criticised, but most patients did not object to the teaching of medical students at the bedside. Twenty-four patients would have liked more explanation about why investigations were performed, and 38 thought that they had not been told enough about the results of their investigations. This lack of information led to anxiety and fear. The findings suggest that more effort is needed to improve communication between doctors and patients.

1673. WILSON-BARNETT, J. and CARRIGY, A. **Factors influencing patients' emotional reactions to hospitalization.** *Journal of Advanced Nursing*, London, 1978, May, vol. 3, no. 3, pp. 221-229.

This is a study of factors causing distress, particularly anxiety and depression, among medical ward patients. A longitudinal design was used to trace patient's emotional responses throughout their stay in hospital. Personality assessment, illness classification, social status, sex and age variables were examined to establish associations between events and emotional reactions. A trait measure of emotionality was shown to have a strong association with anxiety and depression responses in this sample. This test is thought to be of use in identifying patients prone to high levels of these emotions while in hospital.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract No. 1735

HOSPITAL SOCIAL WORK

See also Abstract No. 1710

1674. RASMUSSEN, A. Socialrådgiverens rolle og placering i hospitalssektoren: stigende behov og interesse for socialrådgivning. **[The role and position of the social worker in the hospital sector: there is an increasing need for and interest in social advisory work.]** *Sygeplejersken*, København, 1978, May 24, no. 20, pp. 12-14.

The Danish social system includes very extensive legislation (Bistandsloven—Public Assistance Act of 1.4.76) guaranteeing maintenance of living standards in an emergency, e.g. a mental or physical handicap, admission to hospital, etc. The concept of almoner was unknown in Denmark before 1920, when it was introduced (from England) on a voluntary basis, becoming a salaried profession in 1939. Under the Act, the county social services are responsible for the counselling of in-patients, but there are wide variations between counties in how they put this into effect. Some employ adequate numbers of almoners; some leave the job to nurses, etc. In the county of Copenhagen alone, there is from one almoner to 65 beds (Slagelse) to one per 220 beds (Roskilde), while in other counties there are few or none. The intention of the Act is that each client should have a social worker responsible for his case in his home council offices, but the machinery and time for contact between social workers and hospital staff are inadequate. Matters are more difficult if local authorities refuse to follow almoners' advice on the grounds of expense. The number of cases before local authority social workers is increasing, and also the number of patients in hospital: local authorities will defeat the objects of the Act if they do not increase the numbers of almoners and clarify their status in the overall field of hospital treatment.

1675. CHURCH OF ENGLAND. GENERAL SYNOD. HOSPITAL CHAPLAINCIES COUNCIL. **A handbook of hospital chaplaincy.** London, Church Information Office, 1978, x, 46pp. £0.50

This handbook presents guidance for hospital chaplains working within the National Health Service and cancels 'Notes for the Guidance of Part-time Hospital Chaplains' (revised edition 1970). Aspects considered include: the National Health Service; the hospital chaplain; terms and conditions of service; equipment and facilities; practical guidelines; services; the hospital chapel; other Christian denominations and non-Christian faiths; chaplains' titles; assistant chaplains; hospital church sisters and chaplains' assistants; chaplains' advisory committees; and training. A list of references and circulars produced by the Department of Health and Social Security is included.

1676. GEEST, van der, H. Seelsorge: fremdkörper oder integriert im therapeutischen Geschehen? **[Pastoral care: an alien element or an integral part of the therapeutic process?]** *Veska*, Aarau, 1978, April, vol. 42, no. 4, pp. 194-195.

The hospital chaplain should not work in isolation but as a member of a team which is concerned with the patient as a whole: he should in particular complement the care of doctors and nurses. In order to prepare the chaplain for work in hospitals he has

been able for some years, in Switzerland, to attend 'clinical pastoral training' courses, lasting from two to six weeks, where he is instructed by experienced hospital chaplains in the theory and practice of hospital work and where he can acquire basic knowledge about illness, psychological processes and hospital procedures. The paper includes a sample conversation between a chaplain and a 45-year-old woman in a long-stay ward who has had multiple sclerosis for 30 years and has little sight or speech, who has just returned to hospital after having spent Christmas and New Year at home.

HOSPITAL CARE

See also Abstract Nos. 1620, 1621, 1650, 1656, 1700, 1702, 1711

1677. BEDARD, G., JODOIN, S. and FORGUES, T. Pratique et évaluation des soins infirmiers. **[Method and evaluation of nursing care.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 55-79.

A brief description is given of a system for evaluating nursing care used at the La Salle Hospital in Quebec. Not only is the quality of care given by the individual nurse assessed, but also the techniques in use, the resources available, and staff and patient satisfaction. The contents of the evaluation programme are illustrated in the 11 annexes which follow the article; these include a staff output assessment form, an error report, an accident summary, a staff orientation questionnaire, an admissions questionnaire, a training assessment form to be completed by student nurses at the end of their period of training, and a quality of service questionnaire for the patient to complete.

1678. GRÉGOIRE, D. De la continuité des soins comme paramètre indispensable au concept global de la qualité. **[Continuity of care as an indispensable guide to the global concept of quality.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 32-35.

Continuity of care is paramount for the patient whether he is moving from one department to another within the same hospital, or moving to another hospital, a rehabilitation centre, a convalescent home, or returning home. In the author's view the key person in this process of providing continuity of care is the nurse since she/he co-ordinates all the patient's activities and is in the best position to acquire, and communicate information concerning him.

1679. TILQUIN, C. and others. Evaluation quantitative en soins infirmiers: le système PRN 76+. **[Quantitative evaluation of nursing care: the PRN 76+ system.]** *Administration hospitalière et sociale*, Montreal, 1978, March/April, vol. 25, no. 2, pp. 42-54.

The PRN (Nursing Research Project) 76 system has been devised to help solve the following problems: (i) evaluation of how much nursing care each patient needs; (ii) classification of patients according to need; (iii) assessment of the number of staff required in each unit during each working period; (iv) determination of the size and

composition of the basic nursing team and of the flying squads. The workings of the system are briefly summarized and five tables and two figures illustrate what information has to be collected, how patients are classified, and how the size and composition of the nursing teams are calculated.

1680. LUFT, H. S. **How do health-maintenance organizations achieve their 'savings'.** *New England Journal of Medicine*, Boston, 1978, June 15, vol. 298 no. 24, pp. 1336-1343.

Health-maintenance organizations have been suggested as a way to stop spiralling medical costs. Although many of the arguments have been largely rhetorical, theoretical considerations suggest that the shift from fee for service to a fixed budget for the providers will result in substantial savings. Total costs for enrollees are 10 to 40 per cent lower than those for comparable people with health insurance. Enrollees in health-maintenance organizations have as many ambulatory visits as comparison groups. Most of the cost differences are attributable to hospitalization rates which are about 30 per cent lower than those of conventionally insured populations. These lower hospitalization rates, in turn, are due almost entirely to lower admission rates; the average length of stay shows little difference. There is no evidence that health-maintenance organizations reduce admissions in discretionary or 'unnecessary' categories; instead the data suggest lower admission rates across the board.

HOME CARE, AFTER-CARE

See also Abstract No. 1697

1681. JONES, M. M., HARVEY, J. E. and TATTERSFIELD, A. E. **How patients use domiciliary oxygen.** *British Medical Journal*, London, 1978, May 27, vol. i, pp. 1397-1400.

Forty-five patients in Southampton who received domiciliary oxygen were visited to find out how much they used and how well they were coping. In general, the administration of the oxygen presented no problems and the apparatus complied with the drug tariff. All but two of the patients took oxygen for symptomatic relief, none for more than five hours daily. The help given by the oxygen was relatively slight because its use was limited to one room. The amount consumed ranged from three-and-a-half cylinders per week by three patients to less than one cylinder in six months by 17 patients. The average yearly cost per patient ranged from £500 to £15 depending upon the number of cylinders used.

SPECIAL DEPARTMENTS

WARDS

See Abstract No. 1590

OPERATING SUITES

1682. Opening ondergrondse operatie-afdeling te Arnhem: speciaal 'ombed'-systeem voor heteerst toegepast in Nederland: verbedden van patienten niet meer met handkracht. **[Opening of the underground operating unit of the Hervormd Diaconessenhuis hospital in Arnhem: a special non-manual patient-bed transfer system is used for the first time in the Netherlands.]** *Technische Gids voor Ziekenhuis en Instelling*, Amsterdam, 1978, June 12, vol. 47, no. 1136, pp. 307, 309.

To minimize infection three air-pressure zones have been created, separated by a system of locks: the operating suite with its five octagonally shaped theatres has the highest pressure; a clean zone has the lowest pressure; and the rest of the hospital has the remainder. Air in the theatre is supplied from above through bacteria-resisting filters. To prevent ward beds entering the theatre, patients are wheeled alongside a shelf projecting from the wall at the entry of the clean area. At the press of a button, the shelf slides slowly underneath the patient, a synthetic glass section of the wall is raised and through the gap the patient is transferred onto an adjustable operating table top on a waiting trolley. This whole operation is electronically operated. The trolley is wheeled into the theatre via an ante room where the anaesthetic is given, the top placed on the operating table base and the trolley removed. Around the plateau is an electronically driven revolving mat with above and below strips of ultra-violet light to combat infection. The central store rooms which are equipped with the latest technical devices (such as electric tackles) where beds are cleaned, fumigated and stored, were newly opened last year. The paper includes three pictures.

PHARMACY

1683. GARDNER, M. E. and TRINCA, C. E. **The pharmacy clinic: a new approach to ambulatory care.** *American Journal of Hospital Pharmacy*, Washington, 1978, April, vol. 35, no. 4, pp. 429-431.

A pharmacy clinic has been established to provide consultation and services to medical staff and patients in the ambulatory care department of the Veterans Administration Hospital, Tucson, Ariz. Among the services provided by the pharmicist are: drug therapy consultation and monitoring; drug use review; drug information; and patient education. The operation of the clinic is outlined and some experiences to date are mentioned. The pharmacy clinic assures the staff of the pharmacist's availability for consultation, allows the pharmacist to organize better the time required for consultation, makes the services of the pharmacist available to all out-patients. and provides a good training environment.

1684. SLOGGEM, J. **Drug-information systems for hospital pharmacists.** *Journal of Clinical Pharmacy*, Oxford, 1977, vol. 2, no. 4, pp. 239-245.

The hospital pharmacist has found himself fulfilling a drug-information role, and as a result has produced impromptu systems to meet his own needs. It is argued that the designing and setting up of information systems is a job for a specialist—a systems analyst or information scientist. The information pharmacist should be able to free himself to provide, and where appropriate, evaluate information.

1685. AMERSON, A. B. and others. **Drug information in pharmacy practice.** *Journal of Clinical Pharmacy*, Oxford, 1977, vol. 2, no. 4, pp. 219-225.

The report of the Study Commission on Pharmacy published by the American Association of Colleges of Pharmacy in 1975 indicates that the pharmacist should assume a greater role in providing drug information to both health professionals and patients. The opportunity for this role has been created because of several factors including: ineffective communication of information; difficulty in keeping abreast of new drug developments; and inefficient drug information sources. Factors outside the profession which have determined the pharmacist's current image as a source of drug information are discussed. Suggestions are made which will help the pharmacist to assume a more significant and accepted role as a source of drug information.

1686. MILNE, A. **A pilot study to examine the comparative usefulness of the Iowa Drug Information Service (IDIS) and MEDLINE in meeting the demands of a pharmacy-based drug-information service.** *Journal of Clinical Pharmacy*, Oxford, 1977, vol. 2, no. 4, pp. 227-237.

This study has been carried out to compare the performances of the Iowa Drug Information Service (IDIS) and MEDLINE with respect to their ability to provide relevant information in response to specific requests for information received by Drug Information Centres. Measures of precision and relative recall have been calculated for both systems. The availability of the references retrieved, the suitability of the entry vocabulary, ease of use of the services, relative cost factors and timeliness of the services are discussed. The reasons behind the failure of one system to retrieve references found by the other were investigated and an attempt made to assess the importance of the factors involved.

1687. DANA, W. J. and others. **Drug information services in an oncology institution.** *American Journal of Hospital Pharmacy*, Washington, 1978, April, vol. 35, no. 4, pp. 434-436.

Information requests received over a 14-month period in the drug information service at the M.D. Anderson Hospital and Tumor Institute, Houston, Texas, were reviewed. Requests were classified as to the nature of the questions, category of requester and geographical distribution of both questions and requesters. Inquiries were tabulated as either oncology-related or non-oncology and further divided into one of 12 information categories. Those questions concerning investigational chemotherapy and unproven cancer remedies were tabulated. An average of 104 requests a month were received. Prescribing practitioners accounted for 47.7 per cent of all inquirers. Overall, 39.4 per cent of total requests were oncology-related. The majority (72 per cent) of all requests originated with the institution. The greatest number (17.7 per cent) of requests were of a general review nature, the second greatest (14.3 per cent) were efficacy-related.

1688. CAMPBELL, W. H. and others. **Adverse drug reactions in a disadvantaged population.** *Journal of Community Health*, New York, 1978, vol. 3, no. 3, pp. 205-215.

Adverse drug reactions represent an area of concern in the delivery of medical

care; most recognized negative indices of health can result from the untoward effects of drug therapy. This study identifies: (i) the nature and extent of the adverse effects of drugs; and (ii) estimates the costs of the treatment of those adverse effects in a disadvantaged population. The findings showed that oral contraceptives accounted for almost 26 per cent of the medical care contacts and almost 33 per cent of the estimated costs for treating adverse effects. An incidence rate of approximately 2.3 and a prevalence rate of approximately 2.2 suggest that relatively few people were treated for the adverse effects of drugs. Costs directly attributable to their treatment, including hospitalization but excluding out-patient drug costs, were estimated to be 44 per cent per person per year. Although the adverse effects of drugs did not appear to be a major problem, in terms of their occurrence and potential severity for a disadvantaged population and in terms of their economic impact upon a medical care system, more information is needed if strategies for dealing with them are to be efficient and effective.

1689. LAXDAL, O. E. and others. **Improving physician performances by continuing medical education.** *Canadian Medical Association Journal*, Ottawa, 1978, May 6, vol. 118, no. 9, pp. 1051-1058.

In 1973, the University of Saskatchewan initiated a three-year study of the effect of continuing medical education on the prescribing accuracy of physicians. The frequency of problems in prescribing was determined by the monitoring of hospital records prior to the start of the scheme. Physicians from three rural hospitals selected 12 to 15 problems from the list and followed the project from the pilot stage to its completion. Seventeen physicians at two similar hospitals served as controls. For the period studied the overall problem level was reduced by 20.8 per cent at the study hospitals and by 14.2 per cent at the control hospitals. Expressed as a percentage of possible improvement the overall decrease in problem level was 62.7 per cent for the study hospitals and 32 per cent for the control hospitals. The results showed that an intensive course in therapeutics based upon current problems can improve physician performance.

1690. CHRISTOPHER, L. J. and others. **Drug prescribing patterns in the elderly: a cross-sectional study of in-patients.** *Age and Ageing*, London, 1978, May, vol. 7, no. 2, pp. 74-82.

A cross-sectional one-day survey of drug prescribing and use in elderly in-patients was carried out in Dundee Hospitals. Altogether 873 patients were studied and analyses of prescribing patterns were carried out by patient categories—medical, surgical, geriatric, psychiatric and mentally subnormal—and by major drug groups. While the average number of drugs prescribed per patient on the study was 3.3, which was not excessive, other results highlighted some possible problems of therapy, viz. the wide range of drugs used within drug groups, the common use of psychotropic drugs, dose regimens which although used in a geriatric population differed little from general adult dosages, and which sometimes involved many administrations per day. Examples were described relating to the use of nitrazepam, phenothiazines and tricyclic antidepressants.

LABORATORIES

1691. HAMMAR, L. Automatisering in klinische laboratoria: individuele monster-contrôle mogelijk met Prisma analysesysteem. **[Automation in the clinical laboratory: individual sample control is possible using the Prisma analysis system.]** *Technische Gids voor Ziekenhuis en Instelling*, Amsterdam, 1978, June 12, vol. 47, no. 1136 pp. 300-303.

This system which is quick, selective, immediate and flexible, consists of four processing modules, each with one or two rails, and a mini-computer. Test-tube samples are placed in the central unit in racks of 10, (less if required), and guided past an electronic eye reading their coded labels. Controlled by the computer all samples are then selected for their specific analyses and transferred to the nearest holder in a moving ring of holders. These stop at a processing rail which consists of 30 rings of round racks, each rack carrying a ring of eight test-tubes. The racks are plunged in water at a thermostatically controlled temperature and moved forward when new samples arrive. Each rail provides for eight separate analyses in one stage and speeds can be increased to 300 samples per hour. Analyses with longer incubation periods can be re-grouped over more than one stage or rail. Analytical instruments, accessible from above, can be arranged over 29 positions round the rails. Several measuring techniques (absorption photometry is mostly used) can be adopted. The sample identification system uses self-adhesive labels with codes in lines and colours, still readable when soiled but rejected when damaged. Various administration methods can be adapted to the system, and urgent samples introduced at any time. Results can be checked in an immediate four-column print-out and stored in the computer memory. The paper includes a diagram of the unit, more details and nine photographs.

1692. PARKERSON, G. R. **Labstand: a computerized system for reporting clinical laboratory data in standard units.** *Journal of Family Practice*, New York, 1978, March, vol. 6, no. 3, pp. 611-620.

A computerized system, Labstand, is described which was developed to simplify the presentation of laboratory data for the clinician. It converts data into standard units (SU) on a scale of 0 to 100 identical for all tests to allow immediate recognition of abnormality. Findings of a study using this system which involved 1,412 abnormal laboratory results revealed that the use of Labstand requires a minimal knowledge of ranges and biological measurement units and may indicate that the lower scoring residents using the system have a greater need for such a new system than do the higher scoring residents.

1693. GRIST, N. R. **Hepatitis in clinical laboratories 1975-76.** *Journal of Clinical Pathology*, London, 1978, May, vol. 31, no. 5, pp. 415-417.

A survey of British laboratories in 1970-1974 was continued by a questionnaire sent to members of the Association of Clinical Pathologists in January 1977, using the same form and method of analysis as for the 1973-74 survey. Only nine cases of hepatitis (three of hepatitis B) were reported. The annual attack rate of 34 per 100,000 was only one-quarter of that in earlier years. The findings suggest that control measures have had considerable success.

1694. BARNARD, D. J., BINGLE, J. P. and GARRATT, C. J. **Cost of carrying out clinical diagnostic tests.** *British Medical Journal*, London, 1978, June 3, vol. i, pp. 1463-1465.

This paper reports an analysis of the costs to the National Health Service of biochemical tests performed in the department of nuclear medicine, York District Hospital during the year 1 April 1975 to 31 March 1976. Radiopharmaceuticals were used in all tests. The largest single item of expenditure was the cost of the salaries of the technical staff, while the cost of reagents (including radiopharmaceuticals) was relatively small. The total costs of carrying out diagnostic tests are much higher than is often recognized by those who request them. The use of relatively expensive, commercially available assay kits saves time and gives good value for money. It may be worth taking this into account when planning hospital budgets.

1695. SCHEIERMANN, N. and KUWERT, E. K. Zur Frage der Infektionsgefährdung medizinisch-technischer Assistentinnen durch das Hepatitis-B-Virus. **[Risk of infection with hepatitis B virus in laboratory staff.** *Deutsche Medizinische Wochenschrift*, Stuttgart, 1978, June 30, vol. 103, no. 26, pp. 1065-1067.

While hepatitis B (surface) antigen was not present in 61 student technicians it was present in 4.7 per cent of 87 qualified staff in a laboratory. Hepatitis B (surface) antibodies were present in 6.6 per cent of the students and in 36.1 per cent of qualified staff. These figures show that paramedical staff, particularly in laboratories, are at considerable risk from hepatitis B virus. The need for special hygienic measures, routine blood investigations, the planned placing of staff positive for anti HBs and the value of passive immunization with anti-HBs immunoglobins is stressed.

BLOOD TRANSFUSION DEPARTMENT

1696. MCBARNETTE, L. and others. **The rejected blood donor: comparison between a voluntary and municipal hospital.** *Transfusion*, Philadelphia, 1978, Jan./Feb., vol. 18, no. 1, pp. 69-72.

In 1975, 15.5 per cent of potential blood donors who presented themselves at a voluntary hospital in New York City were rejected; during the same period eight per cent of potential donors at a municipal hospital affiliated to the voluntary hospital were rejected. Variations between the two hospitals in the causes of rejection and the reasons for these differences are discussed. The effect of rejected donors on donor recruitment is examined. The important considerations are: (i) to get medical and other help for the rejected donor; (ii) to keep the rejected donor motivated, so that he returns to donate when his medical problem is solved; and (iii) to emphasize the importance of individual participation in the overall scheme of blood banking so that the rejected donor may act as a recruiter of other donors.

1697. JONES, P. and others. **Haemophilia A home therapy in the United Kingdom, 1975-6.** *British Medical Journal*, London, 1978, June 3, vol. i, pp. 1447-1450.

Data on home treatment for patients with haemophilia A (factor VIII deficient haemophilia) were compiled for 1975 and 1976 from questionnaires completed by directors of haemophilia centres throughout the United Kingdom. There were 48

centres in 1975 and 71 in 1976. The number of patients on or in training for home treatment increased from 267 to 488 in the two years, and a further 241 were considered suitable for home therapy by the end of 1976. Apart from a small (but increasing) number of haemophiliacs on prophylactic treatment, most patients were on low-dose, on-demand regimens. An estimated 55 per cent of the blood product used for home therapy in 1976 was imported from commercial sources. Despite the fact that the number of patients on home treatment has increased (about 60 per cent of the potential population receiving or being considered for it in 1976), inadequacies in the service still remain. In some centres, follow-up is clearly inadequate; about 15 per cent of patients still rely on cryoprecipitate; and too little money has been invested in making the National Health Service self-sufficient in factor VIII production.

MILK BANKS

See Abstract No. 1724

DIAGNOSTIC X-RAY DEPARTMENT

See also Abstract No. 1641

1698. **Applications of computers in diagnostic radiology.** *Medical Technologist and Scientist*, London, 1978, May, vol. 8, no. 5, pp. 8-10.

The most practical application of a computerized system in the diagnostic radiology department would be the keeping and storing of detailed records of patient attendances. A useful addition would be to record the movement of radiographs in and out of the department. Information could be made available to other departments by the use of visual display units. The use of computers in teaching could be extended to the training of radiologists and radiographers. Computerized reporting systems are another possibility, but the variety of diagnoses often attributable to a single radiographic examination might cause problems. The cost of the computer would be compensated for by the time saved and the possibility that the same system could be shared by other departments.

1699. POHLENZ, O. and STROMBERG, G. V. **Planning standards for X-ray departments in general hospitals depending on the workload.** *Electromedica*, Erlangen, 1978, no. 2, pp. 38-43.

The aim of this investigation is to obtain more specific guidelines for planning X-ray departments and to give more information about the requirements of equipment. However this refinement of planning guides will be only useful if the basic data of the X-ray department to be planned can also be made available in the same refined form under the same refined conditions. It is demonstrated that the utilization capacity of an X-ray department can be indicated quickly, but only approximately, by the number of examinations, and it is better to use the number of X-ray 'actions' as a measure. The best demonstration of the utilization capacity is obtained if the Scandinavian points to be expected are calculated from the X-ray examinations. A summary of the guide values mentioned is presented.

REHABILITATION

See Abstract No. 1708

PHYSIOTHERAPY DEPARTMENT

See Abstract No. 1622

OCCUPATIONAL THERAPY DEPARTMENT

See Abstract No. 1622

INTENSIVE CARE UNITS

See also Abstract No. 1663

1700. PIERGEORGE, A. R. **Basic philosophy utilized in development of the intensive-care unit—coronary-care unit concept.** *Journal of Clinical Engineering*, Walnut, Calif., 1978, Jan./March, vol. 3, no. 1, pp. 55-60.

Critical care is made up of three stages: (i) resuscitation; (ii) emergency medical care; and (iii) intensive care in hospital. Every year at least half a million people die from emergencies; at least 40 per cent of these deaths could be prevented if the technology of critical care was applied effectively. The intensive care unit developed from the post-operative recovery room, and the author outlines the history of such units in the United States. The following are recommended fundamentals for intensive care in the hospital; (i) a multidisciplinary team approach to patient care, in a special unit independent of the disease or injury involved; (ii) outstanding nursing care; (iii) a well planned and equipped unit; and (iv) care given 24 hours a day by specially trained staff. Units should be clusters of six to eight individual bed spaces. Minimum requirements for basic monitoring systems and additional accommodation are also given.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 1727

1701. THUNHURST, C. **Quantitative analysis and the planning of the out-patient department.** (M.A.R.U. 3/74) London, Medical Architecture Research Unit, Polytechnic of North London, 1974, 39pp.

This paper constitutes the final report of a research commission, conducted for the Department of Health and Social Security, Architects Division. The paper reviews the development of the out-patient department and the use made of quantitative techniques in the analysis of the out-patient department and in planning and design

generally. The use of the ADAPT/ADEPT suite of programmes developed within the Medical Architecture Research Unit for planning and designing out-patient departments is discussed. Questions are raised about whether these methods can be best applied as a design tool or whether they should be used initially as a research tool in order to investigate the base-line data necessary for any future redeployment of the methods as design tools.

CASUALTY AND ACCIDENT

1702. WHITE, M. S. and GIBSON, G. **Evaluation of an emergency department patient advocacy program.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, April, vol. 7, no. 4, pp. 145-148.

In the patient advocacy programme at the adult emergency department of Johns Hopkins Hospital, first year medical and health associate students provide patient teaching, crisis intervention, emotional support, assistance in patient-provider-family communication, resource referrals, information and assistance in maintaining patients' rights. The programme was evaluated in a three-month study of a control group, patient advocacy group, halo group and placebo group, including 412 subjects in all. It was hypothetized that patients' satisfaction, behaviour and knowledge would improve significantly as a result of the advocate's attention in the order: patient advocacy, halo, placebo and control. Patient interviews and medical records were used to assess the impact of patient advocacy. Results did not support the hypothesis of either improvement or the ranked order. Competition with traditional roles, identification of advocates with providers rather than patients, and placing the needs of the institution over patients were suggested as explanations for the programme's failure.

OCCUPATIONAL HEALTH

See also Abstract No. 1605

1703. TABOR, E. and others. **Prevalence of hepatitis B in a high-risk setting: a serologic study of patients and staff in a pediatric oncology unit.** *Pediatrics*, Evanston, 1978, May, vol. 61, no. 5, pp. 711-715.

The presence of serologic markers for hepatitis B virus (HBV) among 188 patients and 158 employees in a pediatric cancer unit was evaluated. Evidence of past or present HBV infection was found in 33 patients (18 per cent) and in 25 employees (16 per cent). The rate was higher amongst patients receiving chemotherapy (19 per cent) than among those not receiving chemotherapy (7 per cent). The presence of HBV serologic markers, while much higher than generally found among healthy children in the United States, was low compared with previously reported rates, and may reflect the use of screening by radioimmunoassay and reversed passive haemagglutination for hepatitis B surface antigen and the use of all volunteer blood donors. The rate suggests that there may be a less urgent need for the use of hepatitis B immune globulin and hepatitis B vaccine in cancer units than had been previously thought.

DAY HOSPITALS

See also Abstract Nos. 1709, 1731

1704. PENK, W. E., CHARLES, H. L. and HOOSE, T. A. van. **Comparative effectiveness of day hospital and in-patient psychiatric treatment.** *Journal of Consulting and Clinical Psychology*, Washington, 1978, Feb., vol. 46, no. 1, pp. 94-101.

This study compares the effectiveness of day hospital and in-patient psychiatric treatment, using information supplied by patients' relatives and close friends. A group of 24 day patients, spending eight hours a day at the hospital, were matched with 24 in-patients. Information was also obtained concerning an unmatched sample of 79 consecutive admissions. Treatment activities were similar for all patients. All groups showed an improvement two months after treatment started, particularly in the reduction of symptoms. However, the day hospital group showed greater gains in attentiveness and social activities and experienced less disruption in employment. These findings show that day hospital treatment is an attractive alternative, both with regard to treatment and cost, for many, if not all, psychiatric patients.

INFECTIOUS DISEASES AND ISOLATION

See Abstract No. 1695

CHILDREN

See also Abstract No. 1735

1705. DECLERCK, Y. and others. **Septicemia in children with leukemia.** *Canadian Medical Association Journal*, Ottawa, 1978, June 24, vol. 118, no. 12, pp. 1523-1526

Between January 1969 and December 1975, leukaemia was diagnosed in 164 children (90 boys and 74 girls) at Hôpital Sainte-Justine, Montreal. A review of their clinical and autopsy records (followed up to December 1976) disclosed 51 episodes of septicaemia in 43 patients; 57 infectious agents were isolated. Gram-positive bacteria were isolated as frequently as Gram-negative bacteria, each type accounting for 45.6 per cent of all the agents isolated. Only two of the 24 episodes of exclusively Gram-positive septicaemia were fatal, whereas nine of the 23 episodes of exclusively Gram-negative septicaemia were fatal. In this exclusively paediatric population of leukaemia patients, Gram-positive agents have to be considered as potential pathogens, and initial antibiotic therapy must be selected with this in mind.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 1690, 1731

1706. BAUMGARTEN, J. Das Krankenheim: ein neuer Institutionstyp der stationären Krankenversorgung. **[The home for the sick: a new type of institution providing in-patient care.]** *Krankenhaus*, Stuttgart, 1978, April, vol. 70, no. 4, pp. 146-148.

Agreement has been reached between the Berlin *Land* and the Berlin Hospital

Association on the setting up, equipment and management of 'Krankenheime' (nursing homes for long-stay patients). These Krankenheime are intended for patients who do not need all the facilities of an acute or long-stay hospital but who cannot get in their normal environment the medical or nursing care they need. Patients are unlikely ever to be discharged. Facilities for such services as remedial gymnastics and occupational therapy are to be provided. Running costs are not borne by the Health Insurance Authority, as is the case with hospitals, but are borne by the patient himself (or by social security grants).

1707. MORRIS, J. B. and COHEN, C. **A formula for estimating the bed requirements for a department of geriatric medicine.** *Health Bulletin*, Edinburgh, 1978, May, vol. 36, no. 3, pp. 111-114.

The numbers of in-patients and those on the waiting list for geriatric admission within the Angus District of Tayside during September 1977 were classified by sex and age groups 60 to 64, 65 to 74 and over 75. A current bed rate per 1,000 of the population and projected rate for 1981 to 1996 was calculated for each group. Angus is well supplied with beds for the elderly and present demand probably represents an accurate assessment of need. However, the formula used revealed that the standard 15 beds per 1,000 population is too low for the over 75 age group and that 20.6 per 1,000 population for men and 39.4 per 1,000 for women would be needed to meet future demand. Fewer beds would be needed for the younger groups, many of whom are catered for in residential accommodation and sheltered housing.

1708. CHAPPUIS, C. Rehabilitation in der Geriatrie. **[Rehabilitation in geriatrics.]** *Hospitalis*, Zürich, 1978, April, vol. 48, no. 4, pp. 170-172.

The author, a consultant in geriatrics at a Berne hospital, discusses the rehabilitation of elderly patients from its psychological, social and medical aspects. He concludes by answering the question 'is rehabilitation in geriatrics possible?' in the affirmative. Each patient is an individual and must be treated as such. He must be actively involved in planning his own future. Regular assessments must be made of his progress, in discussions with the full team of nurse, therapist, social worker and doctor, and he must be fully prepared for eventual discharge from hospital.

1709. HUBER, F. Die geriatrische Tagesklinik. **[The geriatric day clinic.]** *Fortschritte der Medizin*, München, 1978, May 18, vol. 96, no. 19, pp. 1001-1002, 1036.

Over the past 20 years the geriatric day hospital has established itself as an important halfway house between home care and in-patient treatment. This paper summarizes the main features and advantages of these day hospitals for the care of the elderly.

1710. NOLEN, M. S. and SCHAENGOLD, M. **Social work services in a long-term care facility.** *Journal of Long-term Care Administration*, Washington, 1978, vol. 6, no. 1, pp. 38-45.

This paper describes the role of social work in long-term care by reference to the work of the social service department at the Wilson Health Center, Asbury

Methodist Village, Maryland, U.S.A. A family group scheme informs families of the care their relatives receive and allows families to discuss problems with each other. This scheme has helped the social workers to learn what support services patients' relatives require. To encourage socialization and prevent regression, several small patient groups have been established: the social workers provide continuity, but hope that the groups will become self-supporting. The social service director gives in-service training to the department's employees through a bi-monthly newsletter and the department has also helped nursing assistants to understand their work with the elderly.

1711. McRae, D. C. **An administrator compares long-term care and acute care institutions.** *Journal of Long-term Care Administration*, Washington, 1978, vol. 6, no. 1, pp. 17-37.

There are a number of differences between long-term and acute care which have administrative implications. While acute care deals with a specific medical problem, long-term care is concerned with a combination of social, physical and medical problems, offering treatment on a human rather than a highly technological level. The areas of specific difference between acute and long-term care which are discussed for their effect on administration, are: (i) the role of the physician; (ii) patient care and team planning; (iii) the role of the patient in self-care; (iv) community and family involvement; and (v) management and organization. In the long-term care institution, the administrator may need to stimulate the physician's interest and will become more involved in the delivery of patient care. In management matters, the long-term hospital, with fewer staff and less technology, is more likely to rely on the administrator to make decisions in many areas. Other more peripheral differences are also discussed.

CANCER

See Abstract Nos. 1687, 1703, 1705

EAR, NOSE AND THROAT

1712. Golden, P. and Ulrich, M. **Deaf patients' access to care depends on staff communication.** *Hospitals*, Chicago, 1978, May 16, vol. 52, no. 10, pp. 86-88, 90.

In order to assure equal access to care for deaf patients, hospitals must make certain that their staff can communicate effectively with these patients. Some common misconceptions about deaf people and about how they communicate are discussed. These must be corrected and resources and techniques for staff to use in communicating with deaf patients must be identified and learned. The resources explained include: the patient himself; sensitivity to the visual environment; sign language interpreters; two-way writing; visual communication systems; special health materials; telecommunication; community resources; learning sign language; and a resource book for staff.

CARDIOLOGY

See also Abstract No. 1700

1713. POLLICK, C. **Echocardiography in a district general hospital.** *Postgraduate Medical Journal*, Oxford, 1978, May, vol. 54, no. 631, pp. 297-301.

A referral service for echocardiography was established within Edgware General Hospital, Edgware, Middx. One hundred and three patients were studied and the benefits to defined groups of referrals evaluated. It is concluded that the introduction of echocardiography into the setting of a district general hospital is of advantage to many patients with cardiac disease and should therefore be encouraged.

1714. ANDERSSON, O. and others. **Organization and efficacy of an out-patient hypertension clinic.** *Acta Medica Scandinavica*, Stockholm, 1978, vol. 203, no. 5, pp. 391-398.

A description is given of the diagnostic and therapeutic routines at an out-patient hypertension clinic at Sahlgrenska Hospital, Göteborg, Sweden. The efficiency of treatment in terms of blood pressure control, patient adherence and frequency of side effects is presented. The patients were derived from a screening examination of a random third of an urban male population aged 47 to 54 years. Out of 686 hypertensive men, cared for at the clinic, only 4.2 per cent defaulted during a two-year follow-up. The antihypertensive therapy consisted of single drugs, a diuretic or a B-adrenergic blocking agent, in 32 per cent of the patients. Fifty per cent of the patients had a combination of two drugs: diuretics and B-adrenergic blockers or B-adrenergic blockers and hydralazine, while 14 per cent had the triple combination of diuretics, B-adrenergic blockers and hydralazine. Side effects so serious as to cause withdrawal of a drug occurred in 15 per cent of the patients in the first year and in three per cent in the second year of therapy.

VENEREAL DISEASE

1715. SATIN, A. and MILLS, A. **Measuring the outcome of contact tracing. 1: a description of the patient and contact populations studied.** *British Journal of Venereal Diseases*, London, 1978, June, vol. 54, no. 3, pp. 187-191.

A standard system for health workers to record and handle information on patients and contacts was introduced to five clinics. Information on all the patients interviewed during the first quarter of 1975 was collected and analyzed. An analysis of the characteristics of these patients showed variation between the clinics. However, regardless of what was being measured, there were always differences between men and women. It was found that not all infected patients were interviewed about their contacts. Unless or until contact tracing includes all infected patients, the effect of contact tracing on the control of the sexually transmitted diseases will be of limited value and difficult to assess.

1716. BALSDON, M. J. and others. **A survey of attitudes of patients in a department of genitourinary medicine.** *British Journal of Venereal Diseases*, London, 1978, June, vol. 54, no. 3, pp. 199-200.

A questionnaire concerning clinic organization was completed by 415 patients

attending a department of genitourinary medicine. Most (62.9 per cent) patients preferred to be identified by number rather than by name, and about half (52.7 per cent) did not like mixed waiting rooms. An appointment system as well as an open clinic was liked by twice as many (44.9 per cent) as those patients (23.6 per cent) against a system. More information about sexually transmitted diseases in the form of leaflets, etc., at the clinic was requested by most (79.1 per cent) patients and a similar number (82.0 per cent) felt the department itself should be more widely advertised.

SURGERY

1717. West, R. R. and Carey, M. J. **Variation in rates of hospital admission for appendicitis in Wales.** *British Medical Journal*, London, 1978, June 24, vol. i, pp. 1662-1664.

In a study designed to investigate the variations in rates of admission to hospital for appendicitis in Wales, Hospital Activity Analysis listings were analyzed according to the sex and age of the patients and the month and day of the week of admission. The incidence of hospitalization was greatest among boys aged 10 to 14 and girls aged 15 to 19. The number of admissions was higher on weekdays than at weekends, but there were no seasonal variations. Durations of stay differed between the 17 health districts. It is concluded that hospital admission rates vary mainly because of differing hospital policies. Admission is not wholly governed by the sudden onset of abdominal pain; other factors include the threshold of consultation of each patient, the referral habits of general practitioners, the availability of hospital beds, and the degree to which doctors and patients expect admission.

MATERNITY

See also Abstract No. 1661

1718. Lewis, B. V., Tipton, R. H. and Sloper, I. M. S. **Changing pattern in a general practitioner obstetric unit.** *British Medical Journal*, London, 1978, Feb. 25, vol. i, pp. 484-485.

Over the past nine years in Watford the proportion of hospital confinements has increased and domiciliary confinements have almost ceased. The proportion of patients originally booked into the general practitioner (G.P.) obstetric unit and subsequently transferred to the consultant unit has increased. Most patients are transferred during pregnancy and the numbers transferred in labour are decreasing. The proportion of G.P.s attending their patients for delivery is low: local practitioners appear to be prepared for the consultant unit to supervise delivery with the pracitioner co-operating in antenatal and post-natal care and family planning. There seems little doubt that the success of G.P. units depends on the enthusiasm and interest of practitioners.

1719. Manier, E., Liu, W. T. and Solomon, D. editors. **Abortion: new directions for policy studies.** Notre Dame, Ind. & London, University of Notre Dame Press, 1977, x, 186pp. £7.00

This volume presents papers from two conferences on abortion held at the Univer-

sity of Notre Dame, Indiana, on 26 and 27 September, 1973, and 19 and 20 March, 1975. The papers concentrate on the basic empirical, conceptual, methodological and normative issues which must be resolved before sound policies on abortion can be designed. Topics considered include: abortion and public policy in the United States; membership decisions and the limits of moral obligation; judicial review and public opinion on abortion decisions; abortion and the Constitution in the United States and West Germany; philosophy on humanity; abortion and the social system; philosophers on abortion; and conclusions. An appendix presents comments on the 1976 Supreme Court decisions.

1720. DILLON, T. F. and others. **Midwifery, 1977.** *American Journal of Obstetrics and Gynecology*, St. Louis, 1978, April 15, vol. 130, no. 8, pp. 917-926.

In January 1974 an autonomous midwifery service was formed at Roosevelt Hospital, New York City, to provide an obstetric service for a group of patients favouring management by a midwife, but with physician consultation readily available. A group of 454 patients cared for by midwives were compared with a random sample of 500 patients cared for by attending obstetricians. The two groups were very similar, but operative delivery occurred more often in the group attended by obstetricians. The midwifery group had a low incidence of complications, but those that arose showed that an operating suite must be immediately available. A discussion between several experts concerning this type of obstetric care follows the article.

1721. MENDENHALL, R. C. and others. **Manpower for obstetrics-gynecology.** *American Journal of Obstetrics and Gynecology*, St. Louis, 1978, April 15, vol. 130, no. 8, pp. 927-932.

Following a pilot study, a stratified random sample of all obstetrician-gynaecologists was obtained from the American Medical Association's 'Master File of Physicians'. A total of 875 respondents (56 per cent of the sample) completed a detailed, one-week log of practice activities and a self-descriptive questionnaire. This initial report describes these physicians by practice management as related to age and geography. Practice work load is identified by encounter time per patient, working hours per day and week, and variations related to geographical location and population served. It is suggested that the findings may have important implications for manpower planning.

1722. LAVERS, R. J. and WHYNES, D. K. **A production function analysis of English maternity hospitals.** *Socio-Economic Planning Sciences*, Oxford, 1978, vol. 12, no. 2, pp. 85-93.

In recent years, a number of attempts have been made to explain the output of hospitals by means of production function analysis. In this survey the authors' estimate, Cobb-Douglas and log-quadratic functions form data for the 193 English maternity hospitals. Of the various throughputs in maternity care, the numbers of beds and nurses appear as the most significant determinants of throughput, although the relative quantities actually employed differ from the 'technical' optimum. Returns to scale in the maternity service appear to be, at best, constant. The effects of hospital location and type are also analyzed and they suggest the existence of significant disparities in levels of efficiency between different hospitals.

1723. BARON, D. P. **The economics of hospital obstetrics care.** *Journal of Economics and Business*, Philadelphia, 1978, vol. 30, no. 2, pp. 98-107.

The purpose of this study is to obtain estimates of the average and marginal costs of maternity care, the relationship between those costs and revenue, and the likely effect of further decline in the birth rate. Using data from 803 hospitals for 1971, estimates are made of the birth rate function, maternity ward cost function, and average and marginal costs and hospital pricing. If the birth rate continues to decline the closure of smaller maternity units would result in average cost decreases for the larger hospitals, but the cost of caring for their additional cases would be higher because the marginal costs of the larger hospitals are greater than the average costs of the smaller hospitals. Even though consolidation would imply decreasing average costs, hospitals that use marginal cost pricing (or whatever pricing policy is used currently) would continue to incur losses on maternity cases. Without consolidation of maternity units, declining birth rates will result in increased average costs for the larger hospitals and essentially constant average costs for hospitals with small maternity units, other things being equal.

1724. BEAL, D. and others. **The organization of a human milk bank in a North Queensland hospital.** *Medical Journal of Australia*, Glebe, 1978, Jan. 14, vol. 1, no. 1, pp. 8-10.

The development of a human milk bank with nursing mothers as donors of human milk is described. Breast milk is collected manually, and as aseptically as possible, by the mother in her own home and the milk is transported frozen to the milk bank by a member of the Nursing Mothers' Association of Australia. A sample of expressed milk is also collected and sent to the microbiology department of the Australian Government Health Laboratory for bacteriological examination. The milk bank is sited in the paediatric ward of Townsville (Queensland) General Hospital. Human milk which has been classed as bacteriologically safe is given untreated to hospitalized infants in preference to formula milk. The result is a human milk bank which is administered under medical and microbiological control.

1725. MINDE, K. and others. **Mother-child relationships in the premature nursery: an observational study.** *Pediatrics*, Evanston, 1978, March, vol. 61, no. 3, pp. 373-379.

In an attempt to develop objective criteria for the process of mother-child bonding, 18 premature infants with a birth weight of less than 1,501 gm. were regularly observed alone and together with their mothers during each nursery visit and three home visits, one, two and three months after discharge from the hospital. Results indicate that mothers visit longer and increase their care-taking behaviour over visits; care-taking behaviours are highly intercorrelated; highly interacting mothers also visit and telephone the nursery more and stimulate their infants at home; infants whose gestation was less than 29 weeks did not respond to any type of maternal stimulation, whereas those of more than 29 weeks showed significantly more eye-openings when their mothers touched them.

DENTISTRY

See Abstract No. 1666

PSYCHIATRY

See also Abstract No. 1704

1726. BROOME, A. K. and WEAVER, S. M. **Nursing in mental hospitals: who cares for the patients?** *Nursing Mirror*, Sutton, 1978, June 8, vol. 146, no. 23, pp. 16-18.

This paper presents a method of assessing the ward staff's activities as they already exist, so that the ward manager can have better information on how to match staff resources with patient needs. Eight categories of nursing activities are used: care; administration; work therapy; non-specific therapy; direction and control; staff discussion; personal activity; and patient involvement (applied to all the other activities). A time sampling technique was used to apply the method in a disturbed ward before investigating a behavioural programme. The results are presented in three graphs and discussed. Overall, it was found that the ward staff spend less time therapeutically with patients the more senior they are. Also the more junior and inexperienced members of staff have the burden of therapeutic interaction with patients. Furthermore, domestic staff spend a large amount of time with patients but may not be seen as therapeutic agents.

1727. TODD, N. A. **Psychiatric consultation in a health centre.** *Health Bulletin*, Edinburgh, 1978, May, vol. 36, no. 3, pp. 115-119.

Fifty-four patients seen at the weekly psychiatry sessions at the Gorbals Health Centre were compared in several respects with 56 patients seen at the Victoria Infirmary and 58 at the Leverndale Hospital. Sixty-five per cent of patients seen at the centre were having their first psychiatric consultation, 28 per cent were referred back to their general practitioners and only 11 per cent were admitted to hospital, compared with 35.5 per cent seen at Leverndale. Patients tended to visit the clinic nearest to them, but the most severe cases were referred to Leverndale, of whom a higher percentage were schizophrenic than in the other two groups. The centre clinic was, therefore, a helpful local facility, especially for new patients, but it did not reduce the number of out-patients attending the psychiatric hospital.

1728. TOWELL, D. **Developing services based on large institutions: some organizational requirements.** *Health Services Manpower Review*, Keele, 1978, May, vol. 4, no. 2, pp. 3-6.

Some of the difficulties experienced in developing comprehensive mental health services in situations where these services are currently based on large institutions servicing two or more health districts are outlined. Experience gained in a series of action research and related projects in collaboration with field authorities demonstrates that ideally large hospitals should be continually involved in innovation if high standards of care are to be developed and maintained. The conditions for a model of innovatory hospital organization are specified by a sequence of nine working hypotheses. These can be extended to suggest more briefly the conditions required to facilitate the development of services in the complex of inter-agency systems of which large hospitals are a part. High priority must be given to creating the new organizational and management forms required to facilitate the transformations still necessary in the development of psychiatric services based on most large hospitals.

1729. BEAN, P. **The Courts, the 1959 Mental Health Act and compulsory admission to mental hospitals.** *Justice of the Peace*, Chichester, 1978, June 10, vol. 142, no. 23, pp. 341-343.

The 1959 Mental Health Act had three aims: (i) that as much treatment as possible should be on a voluntary basis; (ii) that care should be moved where possible from institutional to community care; and (iii) that proper provision should be made for cases where compulsion is necessary. The last provision exists to detain patients on doctors' and social workers' recommendations. About 26,000 patients are compulsorily detained every year in England and Wales, the majority on a 72-hour order and without right of appeal. Prior to the Act, the way the Courts handled certification procedures was strongly criticized and led to the courts being dispensed with. However, some lawyers, while admitting lack of medical knowledge, wanted to retain the Courts as the final arbiter. Legislation concerned with mental health involves both the patients' liberty and his right to the appropriate treatment. The author suggests that a patient should be given the right to appeal to a Court within 48 hours of being detained, unless a medical certificate shows he is unfit to attend.

1730. WEAVER, S. M., BROOME, A. K. and KAT, B. J. B. **Some patterns of disturbed behaviour in a closed ward environment.** *Journal of Advanced Nursing*, London, 1978, May, vol. 3, no. 3, pp. 251-263.

As part of a research project concerned with reducing the frequency of disturbed and disruptive behaviour, such incidents have been monitored and analyzed with a view to better understanding their antecedents and thus establishing more effective management policies. A group of disturbed forms of behaviour which appear to be related to each other by 'psychological factors' in the closed setting is of special interest. These arise from and are maintained by the expectations that staff and patients have regarding normative behaviour in a locked ward. It is suggested that the closed setting implicitly defines certain disturbed behaviour as acceptable and that there are direct links between these norms and the level and particular variety of disturbed behaviour on the ward. The dangers of failing to recognize the relationship between disturbed behaviour and the psychological implications of security and illness and particularly of over-reacting to apparent increases in disturbance are discussed.

1731. BERGMANN, K. and others. **Management of the demented elderly patient in the community.** *British Journal of Psychiatry*, London, 1978, May, vol. 132, pp. 441-448.

Eighty-three consecutive patients with organic mental disorder were studied on their first admission to a psychiatric day hospital assessment unit in a general hospital. They were evaluated medically, psychiatrically, and by social workers, re-evaluated after three months, and again after 12 months or at death. The types of care, and the number of days in each setting, were recorded. Nearly three-quarters were dead or in institutions by 12 months: those initially living with spouses did worst, and those with their children did best, while those on their own became long-stay residents in institutions. Family support seemed the most important factor determining continued life in the community, and increased help to families from social services appeared to be needed. The value of earlier psychiatric diagnosis and earlier treatment of physical ills is also discussed.

1732. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. DEVELOPMENT TEAM FOR THE MENTALLY HANDICAPPED. **First report, 1976-1977.** London, HMSO 1978, xi, 58pp. £1.50

This first report of the Development Team for the Mentally Handicapped is in three parts. Part one considers the team's operational policies; part two presents comments on the services provided, the effect of joint planning and joint financing, play, hospital schools, day care, local authority care, and hospital residential services; and part three considers the essentials of local health services for the mentally handicapped. Two appendices are included listing the membership of the Development Team and the projects undertaken between July 1976 and December 1977.

1733. DEVON. COUNTY COUNCIL. SOCIAL SERVICES DEPARTMENT. RESEARCH AND TRAINING SECTION. **Caring for the mentally handicapped: a discussion document.** Exeter, Research and Training Section, Social Services Department, Devon County Council, 1978, i, 130pp. £2.00

This report combines the basic findings of two preliminary reports on West and North Devon and provides further information about the need for services in these two areas of the county. The report is divided into three main sections. Section one provides insight into the people involved with the caring, and their comments and feelings about the situation and the problems. Section two explains the ratings such as dependency, risk and literacy. The final section uses the ratings of section two to assess the need for services such as day-care, short-term care and long-term care. An appendix includes comments that interviewers made at the end of some of their questionnaires and underlines the need for suitable short- and long-term care.

1734. MALIN, N. **Staff attitudes in mental handicap.** Glasgow, Scottish Society for the Mentally Handicapped, 1978, 59pp. £1.25

The material in this booklet was used for an M.Phil. thesis on the mentally handicapped in Scotland. The problems of lack of finance, inadequate facilities, lack of training and differences in staff attitudes are discussed in the light of the services provided. There are three sections to the booklet: (i) what is mental handicap; (ii) care, training and education; and (iii) attitudes in mental handicap at Morston Hospital, Lochhead Adult Training Centre and at Millwood Special School for the mildly mentally handicapped child. A discussion summarizing the three centres is included. There is also a bibliography of 28 items.

1735. CASS, H. and others. **Take six children.** London, National Society for Mentally Handicapped Children, 1978, viii, 48pp. £1.50

This is a short account of an original project involving mentally handicapped children in hospital and young volunteers. Twelve student volunteers worked intensively with six severely retarded children in Harperbury Hospital, near Radlett, Herts. The care needed to set up each programme and the support required to make it work and keep the project going for two weeks is described and the concentration of effort required to produce even small gains in such children revealed. A final summary shows how much of what was achieved by the volunteers was consolidated by the nursing staff in the succeeding year.

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